# THE IMPACT OF GENDER, PERSONALITY, AND EXPERIENCE VARIABLES ON THERAPEUTIC RESPONSES UTILIZED WITH HOSTILE AND DEPENDENT CLIENTS

By

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A number of studies conducted during the late 1960s and early 1970s separately examined various factors thought to affect response tendencies toward overtly hostile clients. Since then much has been written about the influence of the therapist's empathic attributes on the nature of his therapeutic interactions, but the relative impact of this variable had not been explored in relation to hostile clients. The present study attempted to build upon previous efforts cited in the literature, inclusive of the empathy variables, seeking to ferret out the constellation of factors that enhance and those that hinder facilitative responding with hostile clients. Responses toward dependent clients were used as a contrast for comparison, as the dynamics of each client group are seen as opposite solutions to the same underlying conflict.

The following variables were included in this study: gender pairing factors, therapist personality levels of hostility, need for approval, anxiety, affective and cognitive empathy, and experience with the two client types. The specific impact of these variables on therapist endorsement of moving toward (empathic), moving away (directional changing), and moving against (counter-aggresive) responses were measured in an analogue study utilizing structured response alternatives which were rank ordered according to therapist preference.

The most influential variable on facilitative responding was the therapist's self-report of empathy. Affective empathy was positively correlated with preferential ranking of the moving toward response, while cognitive empathy was inversely related to empathic responding and positively correlated with endorsement of the moving against choice.

Female therapists were shown to deal more directly with clients than male counselors, who had a higher rate of withdrawal from clients. Gender pairing seemed to be a more important variable for male therapists, as they had a greater difficulty focusing on the current interactional aspects of the therapy session in opposite sex dyads than females did.

The impact of prior experience with the respective client types was found to be negligible.

Suggestions for furthering research in this area were presented. Similarly, consideration of a training seminar focused on illumination of countertransferential response tendencies and role playing appropriate interventions with hostile and dependent clients was discussed.

# CHAPTER I
# INTRODUCTION

Philosophical writing concerning the understanding and managing of hostility has a long history. Such ancient scholars as Aristotle, Seneca and Plutarch wrote lengthy treatises on the tendency toward an irascible disposition and outlined methods for containing one's anger (Schimmel, 1979). These seminal thinkers believed that anger was a reactive emotion to a perceived injury and prompted behavior designed to extract vengeance on the offenders (Schimmel, 1979). A basic premise underlying psychoanalytic thought is that conflict over acknowledgment or expression of hostile urges is a prime source of anxiety in the individual (Freud, 1935). Hostile exhibitions are common among many character-disordered individuals, including narcissistic, borderline, antisocial, and passive-aggressive personalities (Lasky, 1984). Clients who overtly display their animosity abound and are in need of intervention; however, they are often identified as difficult clients to treat.

The need for increased understanding and more effective treatment of the antagonistic client was evidenced by the devotion of the first issue of <u>The Psychotherapy Patient</u> (Stern, 1984) to articles on the

abrasive patient. The abrasive patient is described by Wepman and Donovan (1984) as narcissistically organized, with a veneer of strength protecting a wounded and fragile self. This individual pointedly expresses his[1] hostility through devaluing and debasing others. His behavior is prompted by his ambivalence about intimacy; while desiring it he is also extremely anxious about the possibility of rejection and fears a reenactment of past injury through disappointment and abandonment (Bar-Levav, 1984; Brothers, 1984; Wepman & Donovan, 1984). Consequently, his interactions with the therapist are geared to procure attention and feed his sense of grandiosity and infallibility while guarding against communication of his loneliness and need for nurturance (Bar-Levav, 1984; Wepman & Donovan, 1984). Characteristically, his attempts to maintain contact are intrusive, lacking sensitivity to the interpersonal cues or needs of others. The overbearing demeanor affords the hostile person a sense of security, however tenuous, and it does provide him a sense of power; and the relationships that withstand it provides the needed confirmation of his-self worth and desirability (Bar-Levav, 1984).

The optimal therapeutic strategy to deter this self-defeating pattern of hostile behavior is to remain sensitively focused on the fragile self. However, the

[1]For reading ease one gender pronoun will be used; however, unless otherwise stated it should be assumed that both genders are being referred to (i.e., his should be read as his/hers).

relentless aggressive behavior can be wearing on a therapist and result in his self-protective withdrawal from a patient, or it can offend the clinician to the point of alienation and stir reciprocal hostile responses (Rogers & Haigh, 1983; Warner, 1984; Wepman & Donovan, 1984). Antagonistic clients who cannot contain their anger often direct it toward their therapist, which leaves the practitioner feeling devalued, uncomfortable, and having to deal with his own anger at the client for placing him in such a position (Brown, 1980). Repetitive hostile encounters designed to maintain distance from the therapist and defeat the goal of self-exploration and acceptance can create distress in the clinician and erode his sense of professional restraint and his ability to remain facilitative (Wepman, 1984). Surveyed counselors (Fremont & Anderson, 1986) report a tendency to become angry with clients who resist treatment through externalizing responsibility for difficulties and limiting exploration of topics. While this response appears to be attenuated by experience, the veteran therapists also indicated angry reactions when verbally attacked by clients, and on the whole there was confusion and discomfort associated with handling such reactions in therapy. Even the most skilled clinicians have trouble maintaining an empathic stand toward clients who consistently malign and attack them as evidenced by Carl

Rogers' transfer of just such a client who was attempting to figuratively "claw out his vitals" (Rogers & Haigh, 1983, pp. 9-10). Therapists are often driven away by the intractable nature of the patient's rage, and the patient's identity as the maltreated, injured party is strengthened when he perceives rejection from the humanitarian therapist (Eigen, 1977). The defeat of the therapist further solidifies the patient's underlying belief in his own repulsiveness and his fury at not being able to have his needs met through interpersonal contact, and thus increases his ire and defensive responding.

The hostile and defensive patient does not fit the mold of the preferred client which has been described by the following cluster of attributes: young, attractive, verbal, intelligent, and successful (Mintz, 1972; Schofield, 1964). It has been suggested that this preference reflects the socially condoned characteristics of therapists who are similarly indoctrinated with this middle-class value system (Berger & Morrison, 1984). Not only are they preferred clients, but the educated, articulate, socially stable middle- and upper-class patients are the ones who tend to remain in treatment, while a high premature termination rate is seen with the more needy and difficult clientele (Garfield, 1978; Heine & Trosman, 1960).

Therapists are most effective with patients who exemplify the ideal, those who are motivated to take responsibility for their desired change and are willing to trust in the potential benefit of the treatment contracted for (Wallach & Strupp, 1960). Investigators (Heine, 1962; Heine & Trosman, 1960; Overall & Aronson, 1963) have found that it was the congruence of patient and therapist expectations for treatment that was related to the continuance of a therapeutic relationship. Having congruent role definitions allows the client and clinician to be united in the goal of treatment and to develop a collaborative alliance. A credible understanding of this phenomena is offered by Wallach and Strupp (1960). They state that the client's belief in the therapist's ability to be helpful fills the caregiver's needs and expectations concerning his ministering role, prompts a warm receptivity to the client, and creates a halo effect concerning treatment. Therapists, like other professionals, choose their line of work because of the satisfaction it brings. Deprivation of the counselor's need to alleviate suffering which occurs with recalcitrant clients often results in desperate measures wherein clinical judgment is clouded in the service of regaining a personal feeling of worth (Brown, 1980; Main, 1957). "The sufferer who frustrates a keen therapist by failing to

improve is always in danger of meeting primitive human behavior disguised as treatment" (Main, 1957, p. 129).

The continued applicability of this last statement is shown in the results of a recent study (Colson, Allen, Coyne, Dexter, Jehl, Mayer, & Spohn, 1986) of therapists' responses to difficult patients. Findings highlighted anger as the predominant countertransferential response of staff toward highly demanding, hostile, emotionally labile, and manipulative patients. These authors further suggested that the treatment personnel routinely overestimated the strengths and underestimated the ego deficiencies of these difficult patients and that their anger sprang from the client's inability to meet the somewhat unrealistic expectations set forth by the professionals. Maintaining a collaborative alliance appears to be more problematic with clients who do not appreciably respond to the therapist's efforts.

Therapist attitudes appear to be related to both the process and outcome of therapy. The clinician's attitude toward his patient influences his diagnosis as well as his estimate of ego strength, social adjustment, his flexibility in treatment approach (Wallach & Strupp, 1960), and the client's continuation in therapy (Shapiro, 1974). Berger and Morrison (1984) found that counselors in training judged an externally motivated and hostile client to have less potential for change, lower ego

strength, and were pessimistic concerning his ability to engage in and benefit from therapy when compared with an equally disturbed but friendlier client. Not surprisingly, the harder-to-treat client was also less well liked by the trainees. These attitudes are also formed early in the treatment process. Rosenzweig and Falman (1974) found that therapist ratings following the second treatment session of felt empathy, positive feelings for, and estimation of, the client's ability to attach in therapy were related to the client's remaining in therapy. It has been suggested by Baekeland and Lundwall (1975) that the client's perception of the clinician's expectations may result in their functioning as self fulfilling prophecies and thus contribute to the eventual psychotherapeutic outcome.

A cynical attitude toward a client is debilitating. It is logical to assume that little effort is put forth by the therapist when the expectation is for a low return on the investment. The more tentative the commitment the less likely it is that any effective work will be accomplished. This common sense notion has been demonstrated empirically via Baekeland and Lundwall's (1975) review of 35 therapy studies which concluded that the clinician's boredom, detachment, and dislike of the patient was consistent with premature termination of treatment.

The guarded prognostic outlook for treatment with hostile patients in part reflects that a theoretical understanding of animosity is not enough to prevent its presence in psychotherapy from disrupting and derailing the explorative process. Consistent therapeutic responding to the abrasive, abusive patient requires much of the therapist, becoming personally involved to integrate and be reflective of the patient's outpouring of rage that will be induced by the threat/invitation to share his true self in an emotionally intimate relationship. The current investigation is designed to build upon previous efforts to isolate factors that contribute to the maintenance of a facilitative posture with hostile clients.

Factors Affecting the Psychotherapeutic Relationship

The infancy stage of psychotherapy was characterized by the practitioner's rigid adherence to the standard doctrine and procedures set forth by the masters. Divergence in thought or practice from the espoused dogma was not tolerated and often resulted in bitter debate, ostracism, and ultimately the creation of another school of thought with its followers supporting a new circumscribed set of beliefs. Along with the growth of psychotherapeutic application to an increasingly wide spectrum of human behavior has come a flexibility in thought and an attempt at integration and utilization of

the concepts of varying ideological camps by the practitioner. This is evidenced by the increasing number of therapists who identify themselves as eclectic. In a survey by Garfield and Kurtz (1976) over half of 855 clinical psychologists contacted stated that they used procedures and conceptualizations from more than one school of thought.

The therapist's theoretical affiliation may reflect his training, his beliefs about human nature, his understanding of the therapeutic process, and his self-schemata (Garfield, 1980). However, while theoretical orientation is associated with a clinician's philosophy of life, it does not necessarily help in predicting his intervention style and actual therapy behavior (Garfield, 1980; Strupp, 1978). Consequently, theoretical orientation is not considered as a viable variable since helpful therapists are often more alike than dissimilar in their treatment of patients. The counselor's respect for others, compassion, and ability to understand another in order to help him alter the manner in which he unwittingly stands in his own way, are the hallmarks of a good therapist (Garfield, 1980; Reisman, 1971; Strupp, 1978).

Experience is another factor that is generally thought to influence the type and quality of interventions provided in treatment. The literature reports contradictory findings concerning how the therapist's

experience level impacts on reported preference of psychotherapeutic style. Wogan and Norcross (1985) surveyed 319 professionally affiliated psychotherapists and found that reports of utilization of psychodynamic interventions and genuine communication increased with experience, while reliance on structured technique and attempts to guide the client decreased with experience. Therapist experience level did not discriminate among type of intervention used, amount of control assumed, or affective distance maintained, according to McNair and Lorr's (1964) survey of 265 therapists working in outpatient departments at Veteran's Administration Medical Centers. Similarly, Wallach and Strupp (1964) reported that experience level was unrelated to the preferred degree of distance between client and therapist, therapist activity level, or flexibility in style in their sample of more than 300 practitioners. While using large samples these studies relied upon questionnaire item endorsement and did not investigate actual or even analogue therapy behavior. Consequently, it is unclear as to whether it is actual therapist behavior or simply self-reporting trends that have changed over the intervening twenty years between studies.

The variable of therapist experience has been considered in the literature on response to hostile clients. A review of the individual studies comprising

this literature reveals that for the most part the subjects were novice clinicians. Practical considerations frequently limit the subject pool to available graduate students with the varying levels of experience being determined by the number of practica taken, thus, the possible range of experience is often quite restricted. There were two studies (Berry, 1970; Haccoun & LaVigueur, 1979) that utilized subjects with a noticeably wider range of experience; however, the results were less than compelling. Haccoun and LaVigueur (1979) reported an experience advantage in the expected direction in terms of assessing and evaluating angry clients, but it was uncertain if this advantage extended to therapy interventions as this analysis was not reported. Berry (1970) did address this latter point and his study found that even seasoned practitioners had trouble handling hostile clients.

Furthermore, client experience has been routinely treated as a homogeneous variable despite the early suggestion of researchers in the field (Russell & Snyder, 1963) that the amount of experience with specific client types and not a general level of client exposure should be the criterion for categorical grouping of expertise. No study to date has investigated this factor in relation to hostile clients. The present undertaking will extend the findings in this direction with the hope of shedding light

on the equivocal results generally found when the experience factor is tested.

Freud (1935) recognized that the psychotherapeutic process was an interpersonal one and that the practitioner's efforts were tempered by his own character structure and his susceptibility to particular countertransferential reactions. Due to the repetitive nature of traits the personality of the therapist has long been considered to be an important influence on the interactive relationship with the client (Freud, 1935; Fromm-Reichmann, 1949; Strupp, 1980a). One personality characteristic which consistently ranked high in terms of its impact upon the effectiveness of the doctor-patient relationship is the therapist's capacity for empathy (Fromm-Reichmann, 1950; Raskin, 1974; Rogers, 1957, 1961, 1975; Truax & Carkhuff, 1967). Empathy has been defined as "understanding the world of the client as he sees it" (Meador & Rogers, 1984, p. 163). Empathy has long been considered by psychoanalysts (Freud, 1921/1961) and humanists (Rogers, 1957) alike to be "the core of the therapeutic attitude" (Emery, 1987, p. 154). The respective definitions of empathy show a convergence of thought. Whether it is seen as a curative factor in itself or as a tool to making more accurate interpretations to benefit the client, the growth in understanding of another occurs via a sensitive perception

of his affective state (Chlopan, McCain, Carbonell, & Hagen, 1985). Kohut's (1984) definition of empathy as "the capacity to think and feel oneself into the inner life of another person" (p.82) captures the fluidity of the process. Truly knowing the client in an empathic manner requires that the therapist listen attentively, tolerate uncertainty and resist premature dynamic formulations, and endure painful and intense emotions which engender a degree of fragmentation of the self while being able to regain enough emotional distance from the client to integrate and process the sensations being absorbed (Berger, 1984). The therapist must be attuned to the subtle changes in the feelings evoked in him and call upon his cognitive faculties of memory and fantasy to grasp the totality of the other's experiences (Buie, 1981). Nevertheless, a clinician varies in his ability to be empathic across clients and particular situations and emotions. Even the most sensitive therapists have limitations in their responsiveness (Kagan & Schneider, 1987).

Winnicott (1960) stresses that empathy is most important in the initial stage of therapy when the counselor functions to establish a "holding environment," communicating acceptance of the client and allowing him to borrow the therapist's strength in the growth process. Empathic understanding may be a key variable in mediating

countertransference reactions to hostile and dependent clients. Given the high incidence of premature termination by difficult clients, it is important to see if the factors that foster empathic responding in initial interviews with such clients can be isolated.

The counselor's empathic ability is affected by other dynamics of the interaction as well as other personality traits of the therapist. It has been suggested (Hickson, 1985) that clients with more transparent personalities are easier to empathize with, as the less ambiguous the stimuli the greater the likelihood of accurate perception and understanding. Clients can present themselves in an obscure fashion to prevent being understood. They resist the temporary vulnerability with another that is necessary for empathy to occur (Buie, 1981). Patients who are dependent on others to maintain their level of self-worth are prone to do this as they distrust others' motivations and acceptance of them; therefore, they hide clues to their attitudes and feelings. Buie (1981) further states that the therapist's ability to empathize is limited in part by the scope of his life experience. There must be some internal frame of reference to understand the cues being received. The greater the life experience either in vivo or vicarious, the wider and more differentiated the range of matching internal referents from which to draw

and the greater the capacity to empathize with a variety of client experiences.

Actual similarity of client and counselor is thought to be related to the level of empathic understanding that the therapist can attain. Kohut (1971) states that "The reliability of our empathy declines the more dissimilar the observed is to the observer" (p. 37). Fromm-Reichmann (1949) also advised that therapists should not work with personalities too divergent from their own because of the inherent difficulties in understanding the client's communications. Likewise, the client needs to be able to identify with the practitioner in order to interject his coping skills (Robertiello, 1971). However, excessive personality similarity between members of the therapeutic dyad brings the problem of overidentification clouding perception of the client (Carson & Heine, 1962) and premature exploration of certain conflicts before the client has had a chance to develop a rapport and feel safe with the counselor (Mendelsohn, 1966). Having very similar personality structures also suggests that the patient and therapist will have the same unresolved psychological issues. Exploration of these nonintegrated emotions may be highly circumscribed in such a pairing due to a lack of mastery of the area and resulting countertransferential reactions (Berger, 1984). Lesser (1961) found that accurate perceptions of client-counselor

similarity were related to the client's feelings of empathic understanding. Overestimating and underestimating similarity led, respectively, to projection and overcompensating behavior which were associated with low levels of felt empathy in the relationship and hindered counseling progress. The therapist needs to be both motivated enough to identify with the client and able to maintain enough detachment to allow for observation, comprehension, and response to the unfolding process (Meares, 1983).

The bulk of the empirical investigations on the ramifications of personality similarity between client and counselor were conducted in the 1960s. Reviewing the literature on personality similarity, Atkinson and Schein (1986) report a total of 14 such studies published prior to 1972 with the majority being conducted in vivo at college counseling centers. An overview of these results follow.

Carson and Heine (1962) found the predicted curvilinear relationship between personality similarity and therapeutic effectiveness in their study comparing Minnesota Multiphasic Personality Inventory (MMPI) profiles of counselor and client, and correlating the similarity with supervisors' ratings of therapy outcome. Caution must be taken in attempting to generalize from this study as the sample was composed of senior medical

students on an 18-week psychiatry rotation. The previous training of these subjects was not mentioned and it is not certain how similar this group is to novice counselors. However, further qualified support regarding the influence of characterological variables is provided by the four studies of client and therapist similarity measured via the Myers Briggs Type Indicator (MBTI) (Mendelsohn, 1966; Mendelsohn & Geller, 1963, 1965, 1967). Mendelsohn and Geller (1965) were able to support Carson and Heine's (1962) finding by showing that clients with moderate personality similarity to their counselors were most satisfied with their therapy experience. Similarity in MBTI profiles was also positively correlated with the client's feeling of being understood by the therapist (Mendelsohn, 1966). One dynamic that was examined extensively in these four studies was the relationship between personality similarity and length of the client's stay in treatment. Similarity in both personality and cognitive and perceptual orientation were found to be positively related to commitment to counseling (Mendelsohn, 1966; Mendelsohn & Geller, 1963, 1965, 1967). However, while a high percentage of clients who did not match their counselor's cognitive and perceptual style attended only one or two sessions and terminated prematurely, there was great variability in the length of counseling when personality similarity was high between

client and counselor. It was noteworthy that these missed sessions and early terminations in highly similar dyads occurred early in therapy, most consistently following the initial interview. The authors concluded that excessive personality similarity contributes to client ambivalence about counseling. While it can facilitate communication, they felt that it also invites a more personal interaction which may be disquieting to the client and result in withdrawal from treatment.

A study by Tuma and Gustad (1957) also demonstrated a positive relationship between client and counselor similarity on dominance, social presence, and social participation as measured by the California Personality Inventory (CPI), and the level of self-exploration reached by the client in therapy. Other studies have shown that dissimilarity on the following personality factors within the dyad is associated with counseling success: original thinking, vigor, and responsibility (Bare, 1967); dominance (Swenson, 1967); need for control (Mendelsohn & Rankin, 1969). Given the mixture of results reported, a generalized statement about the effects of personality similarity between client and counselor is appropriate. Cogent comments require the specification of particular attributes in question. This study will consider the impact that client and counselor similarity on the

attributes of hostility and dependency have upon therapist intervention style.

Theoretical formulations abound concerning the hypothesized impact of the therapist's own hostile urges, anxiety level, and need for approval on the client (Adler, 1972; Fromm-Reichmann, 1950; Kohut, 1971; Maltsberger & Buie, 1974). However, a review of the literature reveals that these variables have been looked at primarily in isolation from one another. Keren-Zvi (1980) took a configurational approach to these and suggested that the next step may be to include the empathy variable in attempting to differentiate therapist response tendencies. The present investigation will take this next step in this line of research.

Another factor that has been considered to affect the therapeutic interaction is the gender composition of the dyad. While past research has shown an overwhelming preference for male therapists (Boulware & Holmes, 1970; Chesler, 1971; Fuller, 1963, 1964), this has changed with therapist preference being related to a client's belief in the gender's capacity to understand the presenting problem (Davidson, 1976; Simons & Helms, 1976; Yanico & Hardin, 1985). The outcome studies tend to show a favoring of female therapists as rated by patients (Fuller, 1963; Hill, 1975; Howard, Orlinsky, & Hill, 1970; Jones & Zoppel, 1982). Females are thought to have a greater

capacity for empathy development (Freud, 1925/1961; Koffka, 1935; Parsons & Bales, 1955). Empirical reviews of the literature lend credence to this notion (Eisenberg & Lennon, 1983; Hall, 1978; Hoffman, 1977). It is unclear if these findings extend to the clinical community as the three studies reviews (Abramowitz, Abramowitz, & Weitz, 1976; Petro & Hansen, 1977; Sweeney & Cottle, 1976) show contradictory results. The empathy studies (Dalton, 1983; Olesker & Balter, 1972) concerned with gender similarity of client and counselor are insubstantial in that they often do not cross client and subject genders, and generalization to a trained population is questionable with two of the four studies cited using undergraduates as subjects.

It has been suggested (Orlinsky & Howard, 1980) that gender alone may not be a powerful predictor of therapeutic outcome, but its effect may be increased or diminished in relation to other variables such as client diagnosis or therapist experience level. The gender composition of the dyad is thought to impact on the response to hostile and dependent affect. The interaction of gender and the aforementioned affect variables have been explored but using undergraduates as therapists (Haccoun, Allen, & Fader, 1976). Studies in this area are not thorough. The flaws include the following: a response to dependency study that used only female clients

(Howard, Orlinsky, & Hill, 1970); only male clients sampled (Rappoport, 1976); therapists responding to only a single client (Johnson, 1978); an extremely small sample size of six therapists (Langberg, 1976). Consequently, the findings are inconclusive regarding the interaction of gender, sexual similarity, and hostile and dependent affect on response style.

One of the primary goals of psychotherapy is to strengthen the individual's adaptive capacity and increase self-esteem (Strupp, 1980a). Differences in the therapist's intervention tendencies toward clients with two contrasting restrictive behavioral styles is the focus of the present study. Hostile and dependent clients were chosen because, while the presenting behavior patterns are polar opposites, they are each defensive solutions to an underlying sense of vulnerability and fear (Horney, 1950). Feelings of helplessness are overt in primarily dependent persons and primary but repressed in hostile clients, while the reverse is true of anger in these types. The extremes of either of these affects can be difficult for counselors to respond to in a therapeutic manner. The differential response tendencies of therapists will be considered in relation to the following factors: client affect; gender pairings; experience levels; therapist personality.

The literature review that follows briefly considers the theoretical underpinning of hostility and dependency and a general understanding of countertransference. Frequent therapist response styles and appropriate strategies are discussed in reference to hostility and dependency. Empirical studies concerning client hostility and dependency and the relevant findings are examined. The contribution of a number of factors such as gender pairing, experience level, and personality characteristics of the therapist to the clinician's interventions style is under consideration. Are these the factors to which Winnicott (1949) refers when he suggests that it is the maturity and emotional stability of the practitioner that determines his response despite similar sentiments elicited by certain patients in a wide variety of therapists? The central question to be answered is: In what way does the gender composition of the dyad, the previous exposure to the respective client types, and the therapist's empathic capacity in conjunction with his anxiety, hostility, and need for approval impact upon his treatment of hostile as opposed to dependent clients? The study is designed to further the response to this question and obtain clues to making therapy with hostile patients a more stimulating and productive learning experience.

# CHAPTER II
# REVIEW OF THE LITERATURE

## Hostility

Webster (1980) defines hostility as a feeling or expression of enmity, ill will, unfriendliness, and antagonism. While hostility is defined by Buss (1961) as a predisposition to evaluate people and events in a negative fashion, it is considered to be an enduring attitude that has the characeristics of a trait (Keren-Zvi, 1980). Different writers have theorized as to the cause of animosity in others. Horney (1950) has stated that hostility arises in response to the perception of an unfair frustration. She states that the accompanying feelings of helplessness and hopelessness in the face of maltreatment trigger enmity which decreases with a corresponding increase in assumption of responsibility for the interaction and the perception of effectiveness. The notion that deprivation leads to animosity was put forth by Harry Stack Sullivan (1965) when he hypothesized the child's first experience of loss through weaning may result in an aggressive hostility. He also commented on his observation that rage is often expressed when a person experiences terror, noting for example the infant's rageful response when physical restraint interferes with

breathing. Layden (1977) further documents the occurrence of this behavior in the animal kingdom. Taking an evolutionary viewpoint he sees hostility as having developed to allow assumption of a position of superiority and thus ensure self-preservation. Echoing the connection of deprivation to animosity he states that the curtailment of biological need fulfillment leads to a deficiency in respect that results in feelings of inferiority. Both Layden and Horney are in agreement that "inferiority generates hostility" (Layden, 1977, p. 6).

Horney (1945) has theorized that hostility festers if not expressed and results in anxiety and feelings of inferiority. She states that anxiety is caused by "feelings of helplessness and isolation in a world considered to be potentially hostile" (Horney, 1950, p. 297). Sullivan (1953) also makes the connection between anxiety and hostility, as he suggests that anger is expressed in order to allay the experience of anxiety. The two emotions tend to feed upon and reinforce each other, with the high level of fear providing self-justification for hostile reactions (Horney, 1937).

Horney (1950) further hypothesizes that fear of rejection is the particular insecurity that underlies hostility. According to her, an entrenched self-belief that they are unlovable generates anxiety concerning rebuff and, consequently, an antagonistic position is

adopted to protect against further erosion of the fragile self. Feeling defenseless, the hostile person lives out the phrase, "the best defense is a strong offense," in their interpersonal interchanges. The externalization of the self-loathing and envy results in enmity and feelings of superiority. The combination of the underlying fear and narcissistic orientation prompts the abrasive person to think of himself as the injured party (Bar-Levav, 1984; Wepman & Donovan, 1984).

Horney (1945) speaks about the aggressive person whose neurotic solution to fear is the hostile, intimidating stance and whose world view is constricted to seeing only the ill will of others. Thus, an attitude of entitlement and self-righteousness often accompanies their anger. She stresses that these individuals seek success and recognition to affirm their strength and fortify a fragile self-esteem and generate a sense of self-sufficiency. They deny failure as they dread humiliation and are motivated to protect their sense of pride aggressively, not refraining from degrading and embarrassing the perceived threatening object (Horney, 1950). They are unable to directly admit or express dependency needs or tenderness for fear that such vulnerabilities would be exploited by a malevolent world.

Sullivan (1953) reiterates this theme when commenting on malevolence in children. He states that a hostile

countenance is born out of repetitive inconsistent and anxiety-provoking responses to requests for affection and tenderness by important caregivers that promote the association of pain and rebuff to expressed need for emotional sustenance. A person so treated does not feel worth or have self-respect. He develops an extreme sensitivity to personal slights and does not anticipate respectful and considerate treatment from others (Layden, 1977; Sullivan, 1953). Wepman and Donovan (1984) similarly state that ambivalence about allowing oneself to receive nurturance underlies a person's abrasiveness. Their intrusiveness is seen as an aggressive attempt to interact with others from a position that affords a sense of power while maintaining enough distance that they will not have to contend with the threat of intimacy. Kernberg (1975) also ties together parental coldness and vengeance with the adoption of an arrogant and grandiose style by narcissists to defend against overwhelming perceptions of other produced rage. Taking the individual's perspective then, hostile behavior is seen as legitimate and necessary behavior within the context of a Darwinian fight for surivival in a menacing environment (Horney, 1945).

Therapist Response to Hostile Client Affect

Therapists' needs to be able to comfortably explore hostility as its direct and indirect expressions, in the form of anxiety and self-devaluation, underlie many of the

difficulties for which clients seek therapy (Faries, 1958). Hostility is uniformly present in the transference of psychotic and borderline patients (Adler, 1970). Drawing upon her extensive experience with psychotic patients, Fromm-Reichmann (1942) attributed the etiology of many severe disorders to the individual's fear of his own and others' hostility. She pointed out that the culture was engendering conflict by promoting an antagonistic competitiveness while being founded on a moral bedrock of Christian charity to others. She further surmised that attempts to adhere to these antithetical societal mandates resulted in inadequately suppressed animosity that sur- faced as neurotic, psychotic and psychosomatic disorders. Particular examples she offered included: agoraphobia--which she saw as fear of aggressive retaliation for unconscious animosity, unconscious hostility presenting as melancholia, and migraine headaches formulated as expres- sions of repressed hostility (Fromm-Reichmann, 1954).

In work with depressed and suicidal patients, hostility often presents itself in the form of a hostile-dependent relationship. Bloom (1967) investigated the suicides of six patients at a training center and found that the irritating, demanding, and hostile patients evoked countertransferential hostility in the therapist. The therapist attempted to suppress this response and this

denial resulted in a lack of awareness of the patients' enmity and the strength of their destructive urges, as well as an unconscious denial of protection of the client at a critical point in therapy. In each case the therapist was defensive about countertransferential hostility, and the suicide occurred within two weeks of a perceived rejection by the therapist. The therapists had moved away from and become less available to these hostile patients both physically, through a decrease in the frequency of sessions, and emotionally, through a withdrawal of involvement which was represented by a lack of exploration of the transference. Alexander (1977) also commented on the therapist's need to be aware of his hostility toward the suicidal patient, stating that denial of resentment can build to feelings of exploitation and result in a detachment from the client and his true emotional state.

Theoretically, it is believed that hostility results from narcissistic wounding and reflects an underlying sense of deprivation and envy which is expressed in contempt for the satisfaction of others (Buie, Meissner, Rizzuto, & Sashin, 1983). It has also been suggested that many therapists experience their client's hostility as a narcissistic wound to their own image as a healer and that therapists with unresolved issues about their own anger and destructive impulses react defensively to client

hostility as opposed to reacting therapeutically (Faries, 1958; Formento, 1980). If the therapist is uncomfortable with his own hostile urges, he often reacts punitively, withdrawing from or attacking the patient for making him aware of his own angry feelings (Nadelson, 1977). The tendency is to attempt to control the patient's hate and destructiveness because they call forth recognition of these same unsavory characteristics in the therapist, which threatens the therapist's idealized image of himself as a rational, objective person who has achieved great control of his impulses (Epstein, 1977). The counselor often tends to become directive and content-focused in the face of client hostility. It is hypothesized that this occurs because of the counselor's fear of the ramifications of the exploration of a personally threatening issue (Hector, Davis, Denton, Hayes, Patton-Crowder, & Hinkle, 1981). It is further postulated that even if the therapist can control his overt response to the client's hostility, his negative response will be communicated unconsciously and result in mutual rejection between therapist and client (Epstein, 1977).

Inability to maintain a therapeutic stance is also evidenced by a loss of cognitive flexibility in attempting to understand a patient's antagonism. Adler (1970) states that the patient's hostility in therapy may spring from any of the following motivational sources: the expression

of a rage reaction due to an anticipated rejection by the therapist; the concealment of more threatening wishes for nurturance; the devaluation of the therapist, which is designed to undercut the impact of the therapist's anger should it be projected onto the client; and a reenactment in the transference of earlier perceived parental devaluation. Often, only one of these possible motivational sources is considered in attempting to understand the patient's animosity. The patient's hostility is frequently seen as a defense against recognition of his dependency needs, and the practitioner then focuses on the presumed underlying needs without adequate investigation of the patient's more overt feelings (Eigen, 1979). While this serves to make the client's demeanor more palatable to the counselor and allows for the retention of a warm and nurturing stance, the relationship is based on an illusion. Consequently, the counselor is not being genuine and the client is denied the experience of being truly known and understood.

Curtis (1982) considers the constructive channeling of hostility to be a key issue in therapy, one which often determines the overall success of treatment. He suggests that ineffective management of animosity in therapy often results in both further decompensation and premature termination of clients. Given the prevalence of hostility conflicts in therapy, it is important to pinpoint the

factors that interfere with the therapeutic exploration of animosity. Managing the antagonistic client is a complicated endeavor. While the therapist must remain empathic in his approach, benign understanding is not necessarily helpful as the therapist is often perceived as weak and rendered impotent by the client. The practitioner needs to demonstrate to the client that he is capable of managing the effects of the client's anger towards him, that while he acknowledges the client's anger it will not cause him to reject the client or retaliate in kind, nor will it frighten or destroy the therapist. Reacting defensively to the client's hostility increases the power of his anger and serves to perpetuate and solidify the interpersonal style that the client is currently limited to. The therapist needs to establish a dominant position in the relationship in order to engage the hostile client in therapy. Bonime (1976) speaks to this issue when he underscores the necessity of the therapist's responding in an empathic but firm manner to the hostile client. An empirical study by Crowder (1972) also found that submissive countertransferential reactions had a greater negative impact on the therapeutic outcome than dominant countertransferential reactions.

Winnicott (1949) views the eliciting of hostility in others as part of the maturational process to being able to accept love from others. The client needs to

experience reactions to both his negative and positive qualities in order to integrate them into his self-concept. The therapist who responds genuinely to only the client's more positive attributes encourages splitting and does not promote processing the underlying conflict embedded in the ambivalence which the coexistence of love and hate toward significant objects entails (Poggi & Ganzarian, 1983). The client's acceptance and integration of feelings of both love and hate towards another reduces his fear of the destructive power of his rage (Spotnitz, 1976), specifically diminishing the fear that the more positive aspects of his personality will be overwhelmed and eradicated by it (Racker, 1957). The greater the client's perceived discrepancy between the therapist's positive, accepting qualities and his own anger and self-involvement, the more the client experiences his own "badness." This intolerable distribution of badness results in a greater need to defend against such awareness, and thus the client's reality testing is further compromised and he is further entrenched in the projection of his own rage (Epstein, 1977). Winnicott (1949) suggests that the therapist should share with his client the negative feelings that have been aroused in him by the client, as the client will trust the credibility of the therapist's communication of care and positive affect only if he has experienced his hostile reactions as well.

Being appraised of the impact that expressions of hostility have upon the therapist allows the client to learn reasonable limits to such expressions beyond which relationships are damaged and the client would reexperience feelings of abandonment and rage (Epstein, 1977; Racker, 1957; Spotnitz, 1976).

While it is helpful to share with the client the impact of his behavior on others, in order for him to incorporate and benefit from this knowledge this communication must be therapeutically, as opposed to antagonistically, motivated. Greenson (1967) suggests that the therapist needs to be able to absorb the hostile attacks of his patient, sharing with the patient only as much of its impact as the patient can tolerate knowing. Lashing out and attacking the client in kind is not beneficial, as it will result in further combatitive behavior. Harsh feedback triggers anxiety and feelings of inadequacy, with the resultant externalization of self-loathing in response to the perceived criticism. It is believed that while anger may be a basis for a sense of self, the hostile client also fears the destructive potential of his anger and will terminate therapy prematurely if he perceives that the therapist is incapable of helping him understand and moderate it. Crowder (1972) lends some empirical support to this hypothesis. He reported that while successful therapists

tended to be rated as more hostile-competitive with clients early in therapy, they resolved this countertransferential difficulty and assumed a supportive-interpretive stance as therapy progressed. The unsuccessful therapists did not resolve their countertransference; they were significantly more hostile-competitive and passive-resistant in their behavior in treatment than the successful practitioners.

It has been shown that therapists interact differently with various types of client because of the interpersonal invitations offered by the client. In an analogue study using trained actors Heller, Myers, and Kline (1963) found that therapists responded to the affective pull of their clients in a set fashion. Specifically, these authors reported that, according to ratings of taped sessions, hostile client behavior led to reciprocal hostile behavior on the part of the therapist, while friendly client behavior evoked friendly, agreeable responses from the therapist. These authors commented that their study highlighted a group reaction, an objective countertransferential tendency, toward the hostile client and did not focus upon the different reactions related to personality idiosyncracies of the therapists. Gamsky and Farwell (1967) reported similar findings in an analogue study with thirty school counselors who interviewed both friendly and hostile

clients. The counselors responded with avoidance and counterhostility to the hostile clients, while they reacted positively with approval and requests for elaboration in conjunction with the friendly clients. The results of the Mueller and Dilling (1968) study lend further support to the idea that client affect invites and often receives reciprocal responses that are not necessarily therapeutic. These authors reviewed actual therapy sessions and found that the client's hostile-competitive behavior towards the therapist was significantly and positively correlated with similar behavior by the therapist, while support-seeking client behavior was correlated with supportive-interpretive responses by the therapist.

Responding in a complimentary manner, defined as a high probability response, to the client's invitations does not necessarily facilitate therapeutic movement. The results of Dietzel and Abeles' (1975) therapy outcome study showed that low therapist-client complementarity during the middle therapy sessions was predictive of successful therapy, as judged by decreased pathology on MMPI profiles. This finding supports the theoretical ideation endorsed by Sullivan (1953), Haley (1963), and Carson (1969) that it is the disconfirming and noncomplementary response of the therapist that is conducive to effective therapy. As Havens (1976)

explains, it is the therapist's violation of the patient's expectations, which he refers to as counterprojection, that forces the client to step outside his limited and neurotic interactional pattern and accounts for growth in therapy. The therapist needs to engage in counter-projective behavior from the beginning of therapy, as it has been shown that the boundaries of the therapeutic interaction become established early in therapy, often within the first three sessions (Strupp, 1980b).

The therapeutic interaction is a reciprocal process, and the therapist's response has been shown to influence the client's communications. The first study to investigate the effect of the therapist's response to the client's hostility was conducted by Bandura, Lipsher, and Miller (1960). These authors coded actual therapy sessions and found a significant and positive correlation between the therapist's approach to the client's hostility and the client's continued exploration of the issue. Similarly, Varble (1968) analyzed sessions over the course of therapy for 16 clients involving 13 therapists and found that clients continued to express their feelings of hostility if the therapist approached it, but discontinued such exploration if the therapist avoided the hostile affect. Conflictual material needs to be addressed in order to be resolved, therefore, the therapist should approach negative affect and invite continued exploration

of it when it appears in therapy. This study showed that approach by the therapist did not inadvertantly reinforce expression of hostility in therapy, as it was found that the frequency of the client's initiation of expressed hostility decreased over time in therapy.

Hostility in therapy can be further subdivided into hostility directed at the therapist and hostility directed at objects outside of the therapeutic situation. Bandura, Lipsher, and Miller (1960) investigated the differential impact of these two variables on the therapist's response tendency. They found that therapists were more likely to respond facilitatively to antagonism directed at others as opposed to hostility directed at them personally. Varble (1968) replicated this finding and extended it by showing that increasing experience did not necessarily alter the therapist's response tendencies. He compared staff psychologists with an average of seven years experience to interns with two years experience and found that while the staff approached their clients' expressions of other-directed hostility slightly more than the interns, the reverse was found for therapist-directed hostility. The author commented that the higher level of approach to therapist-directed hostility shown by the interns may have been influenced by a seminar on countertransference they were attending while the study was taking place. Consequently, the generalizability of this finding is

questionable. The relationship between therapist experience and response to the direction of client hostility was also investigated by Gamsky and Farwell (1966). The results supported Bandura's finding that therapists are more inclined to be facilitative in response to other-directed animosity, but unlike the previous study the experience variable proved to be significant for therapist-directed hostility. The more experienced counselors approached therapist-directed hostility more than the less experienced subjects. It is possible that the contradictory findings concerning the impact of level of experience on therapist response to antagonism may reflect differences in the type of experience the subjects have had. The amount of overall therapy experience does not reflect the amount of experience the therapist has had with particular client types.

## Dependency

The dependent personality has been described as feeling weak, helpless, and inferior with a need to rely on others to nurture and protect him from experiencing the intensity of his vulnerabilities and insecurities (Fromm, 1947). Riddled with feelings of inadequacy, a sense of insubstantialness pervades this characterologically disordered individual who fears the assumption of responsibility due to an underlying self-concept of

incompetency. Believing he is ill equipped to meet the challenge of the world alone, this personality identifies with and emotionally clings to a strong and supportive figure (Millon, 1981). Horney (1945) speaks about the essential self-abasing characteristics of the dependent personality, whom she refers to as invoking an interpersonal style marked by compliance which is geared to obtain gratification of both approval and affection needs and maintenance of the individual's other-directed self-esteem needs. The level of self-esteem fluctuates in accord with the level of approval and support received from significant others (Chodoff, 1972).

The dependent individual is marked by a submissive stance and a chameleon quality in attempting to mold the self to be more pleasing to others, and thus maintain a tenuous sense of security (Millon, 1981). Dependent individuals do not maintain a consistent sense of self; they rely on others to shape their identity and give them substance (Birtchnell, 1984). Assertive demands for respect are missing, due to the individual's perception of inferior status. It is postulated that the excessive submissiveness exhibited by the dependent personality is the superego's response to strong feelings of hostility and opposition to parental figures (Birtchnell, 1984). Hostile urges are repressed, due to a belief that such expressions may tax the relationship and jeopardize

security through loss of the depended upon figure (Millon, 1981). The dependent personality denies anger when experiencing rejection for fear that exposure of dissatisfaction will result in a more complete rejection (McCranie & Bass, 1984). Consequently, while highly self-critical, the individual adopts a naive, optimistic view of relationships to avoid recognition of areas of inconsistency, dissension, or disharmony and to maintain the magical belief that the stronger other can always right things (Abraham, 1924/1927; Millon, 1981).

Deficiencies in the quality of the early attachment relationship between caregiver and infant have been shown to be predictive of excessive dependency behavior in preschool children (Sroufe, Fox, & Pancack, 1983). Inconsistency in response to the infant's emotional arousal is thought to be a key factor in compromising his capacity for autonomous functioning (Ainsworth, 1972; Sroufe & Waters, 1977). The infant that is not comforted or encouraged in times of distress becomes overwhelmed by his affect and learns that he cannot rely on the world to help him master challenges, and thus comes to fear new experiences.

Certain parenting styles have been linked to the development of excessive dependency in children. Bowlby (1977) cites the following as pathogenic parenting styles: persistent indifference or rejection of the child's

request for nurturance; utilization of threats of abandonment or discontinuation of love as a way to triangulate or discipline the child; threats of spousal desertion, homicide, or suicide that establish the fragility of the family unit; and making the continuity of the family contingent on the child's behavior, and thus inducing guilt with each threat of disruption. The following perceived maternal characteristics have been shown to correlate with dependency in young women: mother as the more influential parent, emphasizing conformity as opposed to achievement, and mother's strict and controlling child rearing style (MCranie & Bass, 1984). Dependent individuals are anxious about separation and terrified of abandonment, as they see themselves as helpless and inadequate people who cannot trust their own judgment and decision making skills. They attempt to counter these fears through merger with another. They often become compulsive caregivers to maintain others close to them and thereby meet their own nurturance needs. Dependent persons have not been able to complete the separation-individuation process; they remain anxiously attached to significant figures, fearing that separation will result in rejection and being overwhelmed by environmental demands (Bowlby, 1977). Insecure attachments predispose an individual to restrict his interaction with the world, circumscribing his

explorations because of a fear of defeat and humiliation without the aid of his stronger partner.

The literature frequently links dependency and depression. Dependent individuals appear to be prone to depression (Birtchnell & Kennard, 1983; Chodoff, 1972; Fenichel, 1945; Millon, 1981). Present research on both clinical and nonclinical populations (Blatt, Quinlan, Chevron, McDonald, & Zurdoff, 1982) suggests that feelings of helplessness and dependency may represent an unarticulated characterological depression. These authors report a positive correlation between dependency and the following depressive attributes: impulsive behavior; rumination about possible abandonment; suicidal gestures. The dependent personality experiences depression when constant reasurrance that they are loved is not forthcoming (Bibring, 1953; Blatt, 1974). Birtchnell (1984) contends that the tendency to rely upon the external support and approval of others to maintain self-esteem is the link between dependency and depression.

Bowlby (1977) suggests that many psychiatric disorders stem from deviant attachment patterns to parental figures which are perpetuated in attempts to maintain the same distance from other significant figures. Dependent behavior often serves an adaptive function, as it binds one in a relationship by increasing the other's feelings of competence and influence, thus protecting

another from feeling vulnerable. Lerner (1983) cautions that the dependent individual's reluctance to become more self-directing in relationships is in part governed by the press from the dominant partner to retain the illusion of strength. The systemic destabilization that would result from the individual's increased autonomy poses a realistic threat to the security of the relationship. The individual must go through a process of growth in order to be willing to take such a risk. Transactional theory (Symor, 1977) suggests that dependent individuals move from a position of self-devaluation and other idealization through a period of angry counterdependence and self-aggrandizement before they can establish a sense of self and truly relate in an interdependent fashion that allows them closeness without compromising their identity.

Therapist Response to Dependent Client Affect

The literature contains theoretical writing and empirical findings concerning the therapist's mode of response to dependent clients. Dependency has been defined by Guerney (1956) in terms of the extent to which the client turns to others for advice, information, and evaluations, the amount of structure and guidance required by the client, and the lack of personal responsibility taken for the direction and outcome of therapy. The passive dependent client attempts to gain the therapist's approval and affection by gratifying the therapist's

narcissistic and omnipotent needs. It is easy for the therapist to respond in a complementary manner and become directive and authoritative in behavior. However, the therapist's assumption of responsibility for client change and adoption of a dominant position solidifies the client's feelings of helplessness and characteristic submissive stance and only provides a new external object on which to rely (Lerner, 1983; Millon, 1981). A directive approach can reinforce rather than resolve dependency needs. Rottschafer and Renzaglia (1962) reported that assumption of a directive and leading style, as opposed to a reflective therapeutic approach, appeared to reinforce dependency expression by clients.

The clinging behavior of dependent personalities is often aversive to the therapist because of the depth of client neediness (Groves, 1978). The therapist is likely to react nontherapeutically by distancing himself from the client in a self-protective maneuver to prevent overwhelming feelings of emotional drainage and loss. Millon (1981) encourages the therapist to adopt a close empathic and nondirective stance to increase the client's feelings of competency and individuality. While it seems to be more therapeutically effective to respond with empathy to client dependency, in practice the therapist's response to client dependency is often directive and reassuring (Heller, Myers, & Kline, 1963). Concentrating

on therapists in training (N=18), Bohn (1967) found that therapists were directive and reassuring when confronted with clients' dependency expressions, while tending to avoid clients' expressions of hostility.

Winder, Ahmad, Bandura, and Rau (1962) found management of dependency in the first two sessions of therapy to be a critical factor in the client's decision to commit to or prematurely terminate therapy. Using a sample of 23 patients and 17 therapists, these investigators found that when the therapist approached and encouraged the client's expression of dependency, the client not only continued to explore the issue, but also tended to remain in therapy. Caracena (1965) was unable to replicate this finding, reporting no significant effect of response to client dependency on continuation or premature termination of therapy. However, the author suggests that this discrepancy may be due to the higher levels of dependency approach in Caracena's sample and the consequent restricted range of behavior on which to test the hypothesis of long term therapy effects of approach to client dependency.

The dependent personality sees the therapist as a benevolent protector, envisioning the therapist as a strong but kindly rescuer (Millon, 1981). Theoretically, it is assumed that in order for the client to be able to explore anxiety provoking material, the therapist must

satisfy his dependency needs. Dollard and Miller (1950) contend that the client's desire to obtain the therapist's approval is what initially motivates him to approach therapy and endure the anxieties that a process of self-examination entails. Heller & Goldstein (1961) report empirical findings that support the hypothesis that initial dependency and beneficial expectations of therapy are positively correlated. Many analytic writers claim that the client cannot truly become independent and capable of relying on the self for direction without a period of dependency and the resolution of the related conflicts in therapy. As the client resolves the conflictual material, his reliance on the therapist's strength will decrease. This has been empirically demonstrated by Caracena (1965) and Schuldt (1966).

Caracena's (1965) study revealed that the therapist's approach or avoidance response to express dependency behavior was routinely followed by reciprocal behavior from the client, continuation of expression, or topic transition, respectively. However, the therapist's approach to dependency did not appear to act as a reinforcer, as the number of client initiated dependency statements was not related to the therapist's behavior. Schuldt (1966) was able to replicate these findings. He found that when therapists addressed their clients' dependency needs as they appeared in therapy the clients

continued to examine these needs; however, while the therapists were consistent in their tendency to approach client dependency expressions, the frequency of their initiation by the client decreased over the course of therapy. The therapists in this study were consistently facilitative in response to client dependency needs.

Therapist response to client dependency has been examined in two studies in terms of whether the dependency expressions were directed specifically at the therapist or more generally to others. The results of those studies have been contradictory. Snyder (1963) found therapists responded with a much higher rate of reassurance to therapist-directed as opposed to other-directed dependency. Reassurance is not necessarily a therapeutic response, as it often springs from the therapist's need to quell his anxiety and often directs the client away from an examination and understanding of his conflicts. Schuldt (1966) found that therapists were particularly responsive in approaching client dependency needs directed at them as opposed to other-directed dependency. It is unclear from these two studies if therapists respond in differential manners to direct expressions of transferential dependency or more generalized statements involving other parties.

## Facilitative Therapeutic Stance

### Empathy as the Common Variable

The premise that there exists an ideal therapeutic relationship whose attributes are endorsed by the practicing experts from differing psychotherapeutic schools of thought and supersedes the espoused differences in theoretical orientation was first researched by Fiedler (1950). He investigated the idea that discrepancies in theoretical ideation were semantic in nature, proposing that experienced therapists from divergent schools would endorse a common set of beliefs concerning the components of the maximally effective therapeutic relationship. Although his sample of 15 psychotherapists is small, results of the Q-sort technique revealed high and significant correlations among items described as most characteristic of a maximally effective therapeutic relationship among experienced therapists identifying themselves as psychoanalysts, Adlerian therapists, nondirective therapists, and eclectic therapists. The experts agreed with each other to a greater degree than they did with novices of their own respective schools. The ideal therapeutic relationship was characterized as an empathic one wherein the therapist understands and accepts the patient's feelings and communicates this to the patient and treats the patient as an equal. Interestingly, therapists who had undergone personal

therapy and experienced the role of client strongly agreed with the preeminent importance of these relationship change characteristics. It has also been shown (Peebles, 1980) that personal therapy experience of counselors is positively related to their ability to display empathy in clinical work.

An often quoted contradictory study (Sundland & Barker, 1962) surveyed 139 practicing psychotherapists from Sullivanian, Freudian, Rogerian traditions and found that differences in conceptualization of and reported activity in psychotherapy were accounted for by theoretical orientation as opposed to experience level. While at first these results appear to be incompatible with Fiedler's (1950) study, the discrepancy in findings may be attributable to the difference in dimensions of items available for endorsement between the two studies. Sundland and Barker (1962) removed all items from the questionnaire that "were largely expressing that empathy was important and that the therapist could empathically relate to his patients . . . [as they] . . . did not discriminate among therapists in the pilot study" (p. 210). They removed what was the common variance amongst therapists' beliefs, and in their discussion suggested that the uniformly agreed upon empathy variable may be a component of effectiveness in therapy that is independent of theoretical orientation. Wogan and

Norcross (1985) obtained similar results in their investigation of 319 practicing psychotherapists identifying themselves as behavioral, psychodynamic, and eclectic therapists. Despite theoretical difference in professed technique among the three groups, the reliance on therapist communicated empathy, warmth, and genuineness as therapeutic interventions was common to therapists from these dissimilar orientations. Raskin's (1974) study showed empathy to be consistently ranked first among 12 variables used to describe the ideal therapist by 83 practicing therapists representing 8 different therapeutic schools of thought.

Reports indicate that level of therapist experience is a contributing variable in the therapist's ability to respond empathically to clients. Mullen and Abeles (1971) rated client sessions across the stages of therapy from 36 different therapists and found that experienced therapists were more consistent in responding empathically to clients than the relatively inexperienced group of interns and practicum students studied. They found experienced therapists were more aware of the variety and contradiction in feeling experienced by clients, while neophyte therapists tended not to differentiate communicating warmth and nurturance with maintaining an empathic stance.

There is evidence that experienced, effective therapists of different orientations are similar in active therapy behavior, offering high levels of the triad of core conditions outlined by Rogers (1957) namely, unconditional positive regard, empathy, and genuineness. Sloane, Staples, Cristol, Yorkston, and Whipple (1975) reported that a review of therapy tapes from well-known, experienced behavioral and psychodynamically oriented therapists demonstrated high levels of accurate empathy, genuineness, and unconditional positive regard. Rogers (1975) states that the provision of empathy by the therapist is the key to the process of change as it is positively related to the amount of self-exploration engaged in by the client. He cites both Barrett-Lennard (1962) and personal communication of R. Tausch showing that the amount of empathy communicated within the second to fifth session is positively correlated with future success or failure in therapy. Berger (1984) states that the curative function of empathy can be understood either as a means to allowing exploration and insight or as provision of an experience of shared emotional catharsis and acceptance that had been lacking in the person's earlier life.

The literature concerning the relationship between empathy and therapy outcome is not as clear as the previously discussed value placed on empathy by practicing

psychotherapists. Parloff (1961) found that outcome measures of decreased discomfort, increased feelings of competence and self-understanding, and premature termination of group psychotherapy patients were related to the empathic quality of the therapeutic relationship. Reviewing 166 outcome studies prior to 1969 led Luborsky, Chandler, Auerbach, Cohen, and Bachrach (1971) to conclude that there was a consistent relationship between empathy and outcome. Patterson (1984) highlights that this positive relationship has been shown across a diverse client population with highly varied problems. When utilizing observer ratings of therapist warmth (33 studies) and unconditional positive regard (25 studies), two-thirds of the studies showed a positive correlation with outcome, while the remaining third were equivocal (Orlinsky & Howard, 1978). The review by Truax and Mitchell (1971) also suggested that the core conditions were associated with positive therapeutic outcome. However, Lambert, DeJulio, and Stein (1978) highlight that reanalysis of these data shows that the relationship between the facilitative conditions and outcome is not as consistently predictable as once thought. They do suggest, however, that a moderate relationship does appear to exist between these two sets of variables and attribute some of the discrepancy to methodological problems, such

as inadequate sampling of therapy behaviors and utilization of observer ratings of empathy as opposed to client perceptions of empathy. They report low correlations among empathy ratings from various perceptions--judge, therapist, client, and trait measures. To date the client's perception of feeling understood has appeared to be most consistently associated with outcome (Free, Green, Grace, Chernus, & Whitman, 1985; Gurman, 1977). This finding supports Rogers' (1975) theoretical contention that clients are the best judges of their therapist's degree of empathy.

The other two reviews (Mitchell, Bozarth, & Krauft, 1977; Parloff, Waskow, & Wolfe, 1978) which argue against the primary relationship of empathy to therapeutic outcome are not convincing, as they rely on studies having a very low and restricted range of empathic therapists. They discount the preponderance of evidence of a positive relationship between empathy and outcome, while emphasizing the flawed studies that did not find such a relationship. Their basic argument is that empathy cannot be considered a necessary and sufficient condition of therapy, as its presence does not always result in client change. This appears to be an unfair expectation, given both clinicians' imperfect empathic abilities and the limitations of our research methodology to assess subtleties in client change over an extended period of

time. Furthermore, as Patterson (1984) argues in his review of this controversy over the efficacy of empathy, despite the biases of reviewers and the multiple references to the supremacy of therapeutic technique, ". . . there is no good evidence for the effectiveness of other approaches in the absence of these conditions [empathy, warmth, and congruence]" (p. 435).

Another reason for the confusing findings concerning the relationship between empathy and therapy outcome has to do with the multidimensional nature of the concept of empathy and which aspects are being measured (Davis, 1983; Deutsch & Modle, 1975). Two types of empathy have been differentiated in the literature--cognitive empathy and affective empathy. Cognitive empathy refers to the ability to intellectually perceive the position of another and accurately predict another's feelings and thoughts. This type of empathy is often referred to as role-taking empathy. Affective empathy refers to the tendency to resonate with another's feelings, to allow yourself to vicariously experience the emotion that another is communicating. It is thought (Gladstein, 1983) that affective empathy develops prior to cognitive empathy, but apart from the developmental sequence these two components of empathy are believed to be tapping separate characteristics (Deutsch and Modle, 1975). Recent research (Davis, 1983) suggests that indeed these may be

two separate attributes, as measurements of each have different and theoretically predictable patterns of correlation with emotional and cognitive subscales on the Interpersonal Reactivity Index, a multidimensionally constructed empathy measure (Davis, 1983).

A three-stage empathy cycle has been proposed (Barrett-Lennard, 1981). The emotional resonation occurs first with the counselor losing the distinction between self and other and temporarily merges with the client. This merger is then transformed into a conscious and distancing cognitive inferential process wherein the "as if" quality is restored while moral judgments remain suspended. The third is the communication of the experience and understanding of the other's reality (Berger, 1984; Gladstein & Feldstein, 1983). Different abilities are required for each of the three stages. An analogue therapy study conducted by Corcoran (1983) showed a significant negative correlation between empathic resonation and emotional separation, while the communication of this empathy was unrelated to maintenance of self-other differentiation. It is clear that those high in affective empathy can recognize the feelings of others, but it is not clear if this ability translates into empathic communication of those feelings. While the feeling may be experienced, the vocabulary to identify it

or the courage to express it may be absent (Kagan & Schneider, 1987).

It has also been suggested that affective empathy may actually hinder the therapeutic process during the problem identification stage, as it has been hypothesized that counselors high in affective empathy may easily become overwhelmed with their client's emotion and have to psychologically withdraw from the client in a self-protective fashion (Gladstein, 1983). Peabody and Gelso (1982) conducted a counseling analogue study and found that therapists who were aware of their own emotional resonation and countertransferential feelings also tended to withdraw from seductive clients when their reactions were too strong. They found that while they were able to pick accurate empathic response, they consistently chose responses that were a generalized statement of the client's emotional state and did not involve themselves or the therapeutic relationship personally in reflecting the source of the affect.

It is suggested that the therapist's level of cognitive empathy may be a key variable in his ability to stay with and explore the negative affect presented by his client. This relationship appears to be conceptually based on the positive correlation found between the therapist's emotional stability and his level of cognitive empathy. Persons high in cognitive empathy are described

as well-adjusted, warm, flexible, optimistic, emotionally mature, and tactful (Dymond, 1950; Hogan, 1969). They have been found to be more effective communicators because they tailor their responses to the needs of the audience (Hogan & Henley, 1970). Empathy has also been positively correlated with ego development, as measured by Loevinger's Sentence Completion Test (Carlozzi, Gaa, & Liberman, 1983). This is a logical connection as cognitive empathy requires the maintenance of self-other differentiation, which in turn rests upon a securely developed sense of self (Deutsch & Modle, 1975). Persons who are high in role-taking empathy tend to be accurate in their self-perception (Mills & Hogan, 1978) as well as their perceptions of others (Borman, 1979). Comparisons of empathy scores with other personality measures such as the Thematic Apperception Test (TAT), Rorschach, and the California Authoritarianism Scale, show positive correlations between empathy and other attributes of a well-adjusted personality such as warmth, security, interest in relating to others, and awareness of and control of emotions (Dymond, 1950). Studies have also shown a corresponding negative correlation between empathy and maladjustment, as measured by the clinical scales of the Minnesota Multiphasic Personality Inventory (Hogan, 1969) and specifically with trait anxiety, as measured by

the State-Trait Anxiety Inventory (Deardoff, Kendall, Finch, & Sitarz, 1977).

## Countertransference

It has been stated that the therapist's personality is his most important tool (Reik, 1948). However, this tool is an imperfect one and at times the inherent flaws contribute to difficulties in maintaining a facilitative posture with clients in the form of countertransference. Freud (1910/1957) was the first to mention counter-transference. He defined it as the therapist's neurotic transference reaction to the client's transference. Countertransference was seen as an impediment to treatment and these infantile ideas were obstacles to be overcome. "We have noticed that no psycho-analyst goes further than his own complexes and internal resistances permit" (Freud 1910/1957, p. 145).

Over the years two schools of thought developed concerning the origin and utilization of this phenomena (Baum, 1970). The classical analysts uphold Freud's original thinking on the concept, believing it is an unconscious process whereby unresolved issues are triggered by the patient's playing out unconscious material; this is to be handled by further personal therapy for the practitioner (Fliess, 1953; Gitelson, 1952; Reich, 1951, 1960). They focus only on the unconscious processes effecting the therapeutic

relationship and exclude reality-based, more objective, reactions to the patient's behavior. This group stresses that the stability of idiosyncratic personality characteristics suggests that the therapist's unconscious needs and conflicts remain relatively unchanged without direct address. Consequently, the situations that evoke countertransferential reactions within a particular therapist are set, and the specific responses are predetermined by the therapist's neurotic resolution of his own difficulties in this area (Reich, 1951). Often the therapist is not cognizant of the specific infantile associations being triggered; the presence of counter-transference is experienced as feelings of anxiety, an increased intensity of affect, blockages in understanding the patient, and boredom within the session (Reich, 1960). Cutler (1958) investigated therapists' responses to patients' presentations of material that had been designated as personally conflictual for the therapist. He found that therapists were unable to maintain their therapeutic objectivity in relation to the personally conflictual material. They continually distorted the relative importance of these issues in the treatment cases and responded defensively when the clients raised these issues.

The alternative school of thought is represented by the following clinicians: Fromm-Reichmann (1949, 1950),

Heimann (1950), Joseph (1985), Kernberg (1965), Little (1951), Money-Kyrle (1956), Racker (1957), Sullivan (1949), and Winnicott (1949). They have expanded the concept of countertransference to include conscious as well as unconscious feelings toward and attitudes about a specific client and suggest that the arousing of such emotions is the patient's doing. This group also views countertransference more positively, focusing upon the insight afforded into the client's thoughts and emotional concerns via reflection upon the therapist's affect and fantasies in connection with the sessions. That the therapist's own emotional reactions to a patient can be used reliably to understand the patient's own impulses and defensive maneuvering, is predicated on the existence of projective identification which links the corresponding unconscious processes of therapist and patient (Racker, 1957). Projective identification proposes that that which is unacceptable in the self and previously experienced as unsatisfactory interactional patterns, are called forth in others in order to try and work through the inner turmoil in an external situation.

While those taking the classical position suggest that the therapist's own specific infantile strivings contaminate the transferential field, Kernberg (1965) asserts that the countertransference of reasonably healthy therapists dealing with the same severely disturbed

patient will be similar and a reflection of the patient's state and not the counselor's problems. He states that the countertransference is an important diagnostic tool in assessing the amount of regression and prevailing affective position of the patient, as in effect, the therapist is mimicking the patient's process (Kernberg, 1965). As Heimann (1950) explains, "the analyst's countertransference is an instrument of research into the patient's unconscious" (p. 81). Through the counter-transference the therapist gains clues as to how the patient was treated by the primary objects in his life, and thus can effect a corrective emotional experience by responding in a manner different from those objects (Zetzel, 1956).

Howard, Orlinsky, and Hill (1969) investigated the congruence of patient and therapist emotions during sessions. Using all female patients and experienced therapists, they gathered self-report data independently on the subjective emotional experience of therapist-patient pairs during multiple sessions once the therapeutic relationship had been established. While acknowledging the limitation that excluding male patients had on the generalizability of the findings, the results of this preliminary investigation were interesting. Both the patient's emotional experience and the therapist's gender appeared to impact upon the feeling state of the

counselor. Female therapists were responsive to the patient's experience of positive transference and intense feelings of dependence. They reported feeling calm when the level of positive transference reported was high, and feeling preoccupied and resigned when it was low. The female practitioners tended to withdraw and not feel nurturing or warm in conjunction with the strong dependency needs of these patients. Concurrence of emotional state was demonstrated with male therapists feeling disturbed by sexual arousal in sessions when the female patients were likewise reporting embarrassing erotic transference. Similarity of subjective experience was found with therapists on the whole feeling withdrawn and a sense of failure when the patients reported low levels of collaborative involvement in therapy. The authors concluded that their investigation supported the contention that the practitioner's feeling in session provided clues to the patient's concurrent emotional state.

Those with a more inclusive view of counter-transference stress that the professional needs to attend closely to his emotional responses and decry the phobic attitude the classical analytical writers have endorsed regarding its appearance. They state that this phobic attitude results in unfeeling, detached, impersonal therapists who repress much of the relevant information

received that could guide appropriate interventions (Heimann, 1950; Joseph, 1985; Kernberg, 1965; Little, 1951).

Countertransference is often denied by the professional fearing that the acknowledgment of such feelings would ruin his empathic stance toward the patient (Epstein, 1977). However, both empathy and countertransference are thought to result from partial identification with the patient, as the unconscious of both contain the same desires. The difference in these two concepts is that the former has a more transient nature, while the latter is a regressive and longer-lasting identification that gets the therapist reembroiled in his own unresolved conflicts (Fliess, 1953; Money-Kyrle, 1956; Reich, 1960; Reik, 1948). Empathy involves the use of only a small amount of energy to identify the fleeting feeling of another, yet the degree of concentration in countertransference is all-absorbing and the boundary between client and therapist affect is blurred (Baum, 1970).

Peabody and Gelso (1982) studied empathy and countertransference, defined as withdrawal from the patient, in counselor trainees and found a tendency for the more empathic counselors to be more aware of their own internal emotional fluctuations, while being less likely to exhibit countertransferential behavior. The authors

suggested that empathy mediated the self-protective tendency to become emotionally detached in psychologically threatening situations. This relationship held up as long as counselors were not overly preoccupied with their internal reactions. These findings lend credence to the theoretical belief that while extensive and differentiating emotional sensitivity is required of a therapist, it is the intensity and duration of countertransference feelings that interfere with the counselor's ability to be effective, as they preclude effortless attention to the patient's needs and fluctuating emotions (Baum, 1970; Heimann, 1950; Winnicott, 1949).

Winnicott (1949) speaks about objective countertransference, the therapist's reality based reactions to the actual personality and behavior of the client. Negative reactions are inevitable when working with severe character disorders and psychotics. Examples of common reactions to client types include the following: feelings of aversion that are often elicited by profoundly dependent persons, the desire to attack which often appears in response to work with demanding and entitled clients, and depressive affect resulting from work with manipulative help-rejectors (Poggi & Ganzarian, 1983). As Little (1951) states, the more disintegrated the patient the more integrated the therapist needs to be, so that the

therapist can allow his ideas to regress associatively, and then to process them on a rational level to help the patient integrate them. The more the practitioner is cognizant of both his love for and his hate and fear of the patient, the less these will unwittingly influence his interaction with the patient (Winnicott, 1949).

It is emphasized that the therapist needs to sustain his feelings in order to cognitively understand what they are revealing about the patient (Heimann, 1950). While being aware of the countertransference, therapeutic progress is inhibited by acting upon these internal reactions and discharging them indiscriminately (Heimann, 1950; Racker, 1957; Winnicott, 1949). The strong reactions must be diluted to a tolerable dosage for the patient to absorb without increasing anxiety and retaliation. Through the therapist's modeling exposure of these titrated doses of his own irrationality, the patient can learn not to fear and avoid such impulses in the self, while sensing insincerity as the counselor attempts to mask his responses, will most likely elicit the patient's hostility as he is once again abandoned in the reality testing function he needs (Little, 1951).

The therapist is particularly vulnerable to defensive reactions to a patient's hostile attack (Glover, 1955) and feelings of hate must be reduced to irritation before they can be effectively communicated (Epstein, 1977).

Counselors wish to be helpful, but often the reparative efforts fail through incomplete understanding of a patient whose conflicts are too similar to the therapist's issues. Such a situation promotes anxiety in the therapist, who will often then withdraw from the patient and offer reassurance instead of treatment. This ineffectiveness also often evokes depressive feelings and defensive anger, which serves to increase the client's hostile attacks and exacerbate a nonproductive relationship (Money-Kyrle, 1956).

Therapist Personality Characteristics Associated with Countertransferential Reactions to Hostile Clients

While in general therapists have difficulty in maintaining a therapeutic posture with respect to an overtly hostile client, not all counselors demonstrate the same degree of difficulty. The individual differences in appropriateness of response may be a function of their own personality characteristics. In addition to empathy, the following therapist personality traits have been suggested as possible links to countertransferential interference in the therapy of hostile clients: anxiety, need for approval, and hostility (Keren-Zvi, 1980).

The linkage of these four variables to counter-transferential responses to hostility is theoretically grounded. Fromm-Reichmann (1950) suggests that the therapist's level of personal security is positively correlated with his ability to respond facilitatively to

his client's hostile reactions. Doing effective work with clients always elicits their hostility because it involves uncovering and dismantling their defenses, which heightens their experience of anxiety and prompts attacks on the force responsible for this distress. The practitioner can correctly perceive the defensive nature of the client's hostility only if he can maintain his own feelings of personal safety and security. When therapists are faced with issues that are personally threatening, they tend to deter the client from further exploration of that area (Cormier & Hackney, 1979). Both self-report (Parsons & Parker, 1968) and physiological measures, along with reports of trained observers (Russell & Snyder, 1963), show therapists become more anxious in response to hostile clients than to dependent or friendly clients. Parsons and Parker (1968) suggest that this is a basic social response that may not be amenable to general counselor training.

When the therapist is made anxious by the client's behavior, he cannot be sensitive to his own internal responses to the client as clues to the client's state because his response has been masked with anxiety. When anxious, the therapist is more directed toward reestablishing and preserving his own identity, and less energy is available to objectively observe and understand the client's perspective (Kohut, 1971; Meares, 1983). In

fact, Cohen (1952) defines countertransference as a disruption in therapeutic communication because of the arousal of anxiety in the therapist.

The tendency of therapists to become anxious in the presence of hostile clients complicates the therapeutic process. Anxiety interferes with the performance of complex tasks (Spence, Taylor, & Ketchel, 1956). An anxious therapist is also seen as less competent (Bandura, 1956), and the client's perception of the counselor's competency has been shown to be related to therapeutic outcome (Orlinsky & Howard, 1978). Typically the counselor diffuses the induced feelings of anxiety by psychologically moving away from the patient. Awareness of their own anxiety did not impact on the therapists' tendency to offer reassurance, ask tangential questions, offer premature and harsh interpretations, or hint at disapproval. These responses were all designed to elicit a transition to a less conflictual topic for the therapist (Bandura, 1956).

Yulis and Kiesler (1968) investigated the effect of therapist anxiety on the response tendency toward hostile, seductive, and neutral clients. The authors found that therapists high in anxiety tended to make content related interpretations as opposed to transference interpretations, irrespective of client type. Counselors high in trait anxiety attempted to focus away from the

client-therapist relationship, and their responses were geared to maintaining distance, being on the whole defensively oriented. This study suggested that anxiety is not the only therapist characteristic that influences responses to hostile clients, as the highly anxious therapist group showed a wider latitude in response to hostile as opposed to neutral clients.

Clinical experience has led to the conclusion that the therapist's fear of his own anger (Adler, 1972) and guilt about personal feelings of hostility (Maltsberger & Buie, 1974) tend to make him inhibit and misperceive the hostile expressions of his clients. It has also been suggested by Greenson (1974) that therapists who tend to respond to hostility with sarcasm and counteraggression in their everyday life will have difficulty in abandoning this style and being facilitative when confronted with hostility in their clinical work.

Treatment with a hostile client means that the therapist must endure periods of devaluation by his client. This ability rests upon the counselor's having a reasonably stable self-esteem. When therapists rely upon a client's admiration to boost their prestige, their spontaneity is interfered, with and insidiously their interventions become motivated by the need to keep the client dependent upon them, thus maintaining their own supply of narcissistic need fulfillment (Fromm-Reichmann,

1949). The therapist's need for approval is conceptually related to his ability to respond to client hostility, as those who can rely on internal self-evaluations will not be prompted to seek assurance from their patients as to their competency and, consequently, they will not be threatened by their clients' disparagements. If the therapist has a need to be liked by his patients he will work toward maintaining harmony in the therapeutic situation and will attempt to avoid recognition of his client's hostile affect, and thereby seriously compromise his therapeutic effectiveness (Maltsberger & Buie, 1974). Hostile attacks by clients can be damaging to both professional and personal self-esteem if these are determined by transitory and external sources of affirmation. Hostile patients present difficult management situations and a possible failure experience, and thus may pose a threat to the therapist who requires professional admiration of his skill to maintain his self-esteem (Keren-Zvi, 1980).

The studies conducted to date on the impact of the therapist's own personality on his handling of a hostile client have been exploratory in nature. The first study probing this issue was Bandura, Lipsher, and Miller's (1960) investigation. These researchers found that therapists who directly expressed their feelings of hostility in their everyday behavior were significantly

more likely to approach hostility directed at others; however, this factor did not influence their ability to facilitatively respond to hostility directed at them. This latter ability was found to be uniformly low across therapists. The therapists' need for approval, as measured by sociometric ratings, was inversely related to their tendency to approach the clients' hostility, irrespective of the direction of the hostility. Similarly, Henry (1981) found that beginning counselors who were willing to place themselves in an unfavorable light by admitting socially unacceptable feelings and behaviors, and were low in hostility expression, responded more appropriately to therapist-directed hostility than their counterparts.

Keren-Zvi (1980) investigated the impact of the therapist variables of anxiety, hostility, need for approval, and level of experience on the therapist's tendency to respond with empathy, avoidance, or counterhostility to hostile clients. These categories of response tendencies are garnered from Karen Horney's (1945) theory of interpersonal styles and represent moving toward, moving away, and moving against character styles, respectively. His sample consisted of 100 psychodynamically oriented therapists, with equal numbers of male and female subjects. The therapists responded via a multiple choice format to four audiotapes wherein client

sex and affect, hostile or nonhostile, were crossed. On the whole, therapists tended to respond with more counterhostility to hostile patients, while being more avoidant with nonhostile patients when the two client types were compared. The results were analyzed separately for male and female therapists, as there were significant sex differences. The female subjects endorsed more facilitative responses than the male subjects. They also reported a higher level of trait anxiety and had less experience than the male therapists. This study found that the level of global experience was not a significantly influential variable on therapist response tendency.

It had been hypothesized that the therapists would respond more facilitatively to nonhostile, as opposed to hostile, clients. This hypothesis was not supported by data generated from either the male or female sample. Both samples responded with essentially equal numbers of facilitative responses to both clients types.

The therapist personality variables under investigagation were significantly correlated with response choices for female, but not male subjects. Females high in trait anxiety, as measured by the State-Trait Anxiety Inventory (STAI), and hostility, as measured by the Buss-Durkee Hostility Inventory (BDHI), responded significantly less facilitatively to hostile patients than subjects scoring

low on these attributes. Further analysis showed that high anxious female subjects tended to avoid hostile patients more and counteraggress against them less. While these results were in the predicted direction, the relationship between the female subjects' need for approval, as measured by the Marlowe-Crowne Social Desirability Scale (M-CSDS), and their responses to hostile patients was opposite to the hypothesized relationship. Female therapists high in need for approval were more facilitative with hostile patients. The author interpreted these findings as suggesting that, while the therapists' high anxiety and hostility levels inhibited facilitative responses to hostility and resulted in avoidant tendencies, a high need for approval may motivate therapists to endure the discomfort associated with approaching client hostility.

The author performed multiple regression analyses on the personality variables for each of the three criterion response categories. The following results were reported for the female subjects: need for approval and anxiety together accounted for 10% of the variance of the moving toward (facilitative) response; anxiety accounted for 11% of the variance of the moving against (counterhostile) response; and anxiety accounted for 17% of the variance of moving away (avoidant) response.

The results of this study suggest that further investigation into the impact of personality variables on response style with the hostile client is warranted. The therapist's level of anxiety appears to be the variable most clearly related to response style. Examination of the response choices offered suggest that it may have been the blatant nature of the responses which influenced their endorsement frequency and, consequently, masked the impact of the personality variables. The author suggested that an open-ended response format might more accurately reflect the impact of the personality variables on the therapist's responses. This suggestion was followed by the present author in an unpublished pilot study, but this format was found to have its own drawbacks (i.e., low interrater reliability in coding of subject generated responses) and the results were disappointing (Appendix A). Keren-Zvi (1980) also suggested that his results may also have been due to the absence of a key personality variable and hypothesized that the empathy level of the therapist may be an influential variable that accounts for endorsement of response style.

## Therapist Experience Level

The experience level of the therapist is a variable that has been looked at in relation to the impact the client's affect has on both the therapist's emotional state and his ability to respond facilitatively. However,

the majority of studies (Bohn, 1965, 1967; Donner & Schonfield, 1975; Henry, 1981; Murphy & Lamb, 1973; Russell & Snyder, 1963) concern novice therapists in graduate school and the varying experience levels are often determined by the current practicum semester. The possible range of level of expertise is thus often limited. It has been shown that novice counselors are more apt to be personally affected by their client's anger than by other emotions expressed by clients. Donner and Schonfield's (1975) in vivo study investigated the amount of emotional contagion experienced by the therapist in relation to three patient groups, those expressing anxiety, depression, and hostility. Their results showed that following a session the more conflicted therapists, as measured by an actual-ideal self-discrepancy, reported an increase in the affect displayed by their patient. While over the period of four sessions there is less emotional contagion shown by the more conflicted therapists in relation to anxious and depressed patients, there is no such decrease in connection with the experience of hostile affect following an interaction with an angry client. Furthermore, over the four sessions even the more stable therapists began to report feeling personally angry after their sessions with the antagonistic client. Therapists in this study appeared to be personally affected by their client's hostility.

Henry's (1981) study also showed that hostile client behavior increases the anxiety level of the therapist. She found that the responses of inexperienced counselors could be characterized as defensive, disapproving, and often inaccurate in perception of the situation when dealing with hostile clients. Unfortunately, experience does not appear to lessen the therapist's anxious reaction to client animosity. An analogue study by Russell and Snyder (1963) demonstrated that the anxiety level of the therapist remains high when working with a hostile patient and does not dissipate with further training and experience. Unfortunately, they do not delineate their experience groupings beyond the labels of "more" and "less" experience categories. Similarly, Murphy and Lamb (1973) found that psychotherapy training resulted in only a minimal decrease in therapist anxiety when confronted with a hostile client. They compared master's level clinical students with school counselors having no psychotherapeutic training and found that while the therapists tended to give fewer direct suggestions than the control group after training, they also tended to interpret more and increased the amount of silence, and neither of these behaviors shows an increase in empathic communication with the hostile client. However, findings from this study should be cautiously interpreted because of the small sample size (N=6) and the relatively short

training period (14 weeks). Training specifically focused upon consistent responding to hostile affect may be beneficial. Hector et al. (1981) found a combination of verbal and modeling strategies to be effective in training beginning counselors to respond facilitatively to both angry and depressed clients.

It is not clear if more experienced therapists respond more facilitatively to client dependency expressions than novice therapists do. Caracena (1965) reported that staff therapists approached dependency more than trainees, while Bohn (1967) found that a semester of training did not significantly decrease the therapists' tendency to be directive in response to client dependency. The variation in range of experience levels in the two studies may account for the conflicting findings. One semester of training may not be enough to affect the therapists' style of handling dependency. However, Bohn (1967) did find that these same therapists were less directive in response to client hostility after the semester's training. He concluded that experience does not necessarily effect response tendencies to these two affects in the same manner. These contradictory findings may also be explained by a different amount of experience with dependent clients between the two samples.

Strupp (1980b) retrospectively analyzed the process of therapy of dependent individuals treated by the same

experienced therapist, one resulting in a successful outcome, while the other was considered a failure. Strupp surmised that the inability to develop a therapeutic alliance in the unsuccessful treatment stemmed from the therapist's adaption of a directive stance and the repeated imposition of interpretations in response to the client's open resistance and negativistic attitude. He offered the analysis as evidence for his belief that, while experience increases effectiveness with motivated clients, this factor has a negligible impact in the treatment of hostile and resistant patients.

The literature comparing therapist response to hostile clients versus depressed clients has touched on both the layman's approach and the trained professional's tendencies. Haccoun, Allen, and Fader (1976) found that untrained college peers responded differentially to angry and sad clients. Angry clients elicited judgmental statements concerning the inappropriateness of the client's behavior, while peer response to depressed clients was supportive involving listening, encouragement of emotional expression, and reassurance. A followup study (Haccoun & Laviguer, 1979) reported that experienced therapists were less negative in their evaluation of angry clients than inexperienced therapists, who saw them as having poor personal controls and as much less able to benefit from therapy than the sad/depressed client. This

study indicated that, on the whole, therapists were more detached and less supportive and eliciting of exploration of emotion with angry, as opposed to sad, clients. It was most unfortunate that they did not report on the effect of experience level on these response tendencies, as the range of expertise was wider than in the previous studies, extending from groups with less than 6 cases to greater than 100 prior patients.

Researchers have investigated the interactive effects of therapist experience level and client attitude focused upon hostile and friendly clients. Berry's (1970) analogue study used two groups of therapists, prepracticum clinical psychology graduate students and professional therapists with at least four years experience. Experienced and novice therapists were both more facilitative with the friendly, as opposed to the hostile, client. While experienced therapists were more empathic with both types of clients than novice counselors, they were unable to maintain their high level of acceptance and warmth with the hostile client. Client affect undermined their ability to provide unconditional positive regard despite their level of training experience. One methodological drawback in this study concerns the fact that each therapist saw only one client, and therefore the individual subject's response to hostile and friendly

clients could not be compared; experience group comparisons were used instead.

Previous studies have compared therapist responses to dependent and hostile clients. Bohn (1965) compared the response styles of inexperienced undergraduates and graduate counseling students with one semester of experience with dependent and hostile clients. He reported that experienced counselors tended to be more nondirective with both types of clients than inexperienced subjects. However, he also found that counselors were more directive with the dependent client, regardless of their training level or their tendency to be dominant in relationships. Therefore, it appeared that both client affect and training effect the therapist's ability to remain nondirective. In addition, Parsons and Parker (1968), using an all male subject pool, compared the responses of psychiatrists, medical students, and undergraduates to both dependent and hostile clients in an initial interaction. They found that all groups favored the dependent client, expressing more acceptance of the client and feeling less anxious in the therapeutic situation. The psychiatrists did differ from the other samples in their verbal responses to the hostile client; they were lower in both verbal aggression and attempts to control the session than the untrained subjects. The authors noted that there was a trend for directiveness to

decrease with increasing therapeutic experience, while being unrelated to educational level attained. Interestingly, they found that while the experience factor effected the therapists' verbal expressions, it did not ameliorate the underlying more negative attitude toward hostile clients, and they hypothesized that this discrepancy would wear on the therapy and taint the therapists' communication as they proceeded past the initial stages of therapy and their more facilitative responses were extinguished.

The studies reported are faulty and replete with small samples, unarticulated experience criteria, restricted ranges of expertise, and incomplete analyses of the data. However, despite these limitations the finding that therapists tend to be directive in response to dependency and are adversely effected by client hostility, coupled with the uncertainty that these undermining response tendencies dissipate with experience, resounds through this review.

## Gender Effects

### Preference for Therapist Gender

The relationship between the sexual composition of the therapeutic dyad and both client and therapist response tendencies has been addressed in the literature. Client preferences for therapist gender has been considered. Fuller (1963), Boulware and Holmes (1970),

and Chesler (1971) found, in line with previous reportings, that both male and female clients preferred male counselors and that cross gender preference from male clients was an extremely rare event. Chesler's (1971) data were impressive, as she surveyed over 1000 clients and of the 25% who stated a preference, the overwhelming desire was for a male therapist independent of client sex. This preference for male therapists has been linked to differential status generalizations between the sexes (Fuller, 1964) and women's socially reinforced low self-esteem level. Fuller's (1963) analyses of actual counseling sessions revealed that both counselor experience and receipt of therapy by a counselor of the preferred gender increased the client's ability to explore and express affect. This study concerned clients seeking help for vocational and educational problems. A followup study was done including personal as well as vocational issues, and included both nonclient student subjects hypothesizing their behavior and the recording of actual client behavior. While again finding that both males and females preferred male counselors when stating a preference, there was a tendency for females to request female counselors when the hypothesized presenting problem was personal in nature (Fuller, 1964). This differed from sampled actual clients' preferences within the same study, wherein female clients requested male therapists for both

vocational and personal problems. It was striking that following therapy, clients who had requested female therapists more frequently changed their stated preference to male counselors than clients who had initially asked for and received treatment from a male therapist. Thus, the tentative suggestion was that same gender requests were limited to hypothetical situations, whereas actual therapy seeking behavior was strongly linked with a desire for a male therapist despite the problem being addressed. This literature predates the feminist movement. These findings are not unexpected, given the limited exposure to women in varying roles that was available at the time.

There has been a change regarding therapist preference through the years as attitudes toward women have been altered and as the pertinent research questions have become more finely tuned. An overview of the more recent studies (Maracek & Johnson, 1980) suggests that frequently the client does not have a preference for the gender of his therapist. When a preference is shown, it is usually the younger, female clients who have a strong desire for a female therapist, as the women are perceived as more empathic, genuinely concerned, and comforting than male counselors (Davidson, 1976; Simons & Helms, 1976), while male clients are rather indifferent to the sex of their counselor (Banikiotes & Merluzzi, 1981; Walker & Stake, 1978; Yanico & Hardin, 1985). Over the years

female therapists have become more acceptable to both sexes. As the studies became more refined in terms of type of stimulus problem, therapist gender preference was shown to be a function of the specific nature of the problem for which subjects were consulting a professional. Males still tend to be chosen for addressing vocational concerns, while females are desired by both sexes for help with such problems as rape, childrearing, pregnancy, and sexual harrassment (Lee, Hallberg, Jones, & Haase, 1980; Yanico & Hardin, 1985). When asked, subjects consistently stated that they were basing their preference on the belief that therapists of the chosen gender would be better able to understand the problems (Boulware & Holmes, 1970; Davidson, 1976; Simons & Helms, 1976; Yanico & Hardin, 1985).

Gender and Empathy

The hypothesis that females on the whole are more interpersonally sensitive and responsive and therefore, more empathic than males, has repeatedly been put forward in the literature (Freud, 1925/1961; Hogan, 1969; Koffka, 1935; Parsons & Bales, 1955). Sociologists theorize that ascribed functions within stereotyped role behavior account for this difference. Specifically, females are expected to adopt the expressive role within the family, seeing to its members' emotional needs and maintaining harmony, while the males are induced to fulfill an

instrumental role, becoming active problem-solvers and task masters with little emphasis on developing their capacity for emotional responsiveness (Parsons & Bales, 1955). Thus, this school of thought views this gender discrepancy as resulting from culturally reinforced role inductions.

The reasons postulated by the psychoanalytic thinkers for this "female empathy advantage" are none too flattering. Freud (1925/1961) felt that women were more empathic because of incomplete resolution of the Oedipal complex, which resulted in an "inherently" weaker ego and superego; being at a more primitive level of psychosexual development, they were more influenced by the irrational affective life of the id. Other psychoanalytic writers (Bakan, 1966; Wyatt, 1967) have similarly suggested that the theorized relatively lower levels of ego development in women are reflected in more permeable boundaries around the self. This diminished sense of differentiation from others is thought to account for the increased sensitivity to others and ability to vicariously experience another's affect.

Hoffman (1977), in his review of the literature on sex differences in empathy, notes that theoreticians do not dispute this popular stereotype and concludes that the empirical findings support this contention throughout the life cycle. His review covered sixteen independent

samples, all but one consisting of children. While the amount of difference between the sexes was not always significant, he did note that in all 16 samples the females outscored the males. He pointed out that the difference was significant on each of the six studies on affective empathy, while the findings were equivocal on the seven studies concerning cognitive empathy. Hoffman (1977) concluded that the sex difference in empathy did not extend to the recognition of affect in others and suggested that females' ability to vicariously experience another's affect may be due to their tendency to imagine themselves in the other's shoes while retaining the as-if quality of the experience, and termed this process a "regression in service of empathy" (p. 718). He refuted the notion that this capacity reflected a lower level of achieved individuation, as he found (Hoffman, 1975) that female children and adults experienced more guilt in reality situations than men, and thus did not have weaker consciences.

Results of a meta-analysis reported by Hall (1978) on 75 studies neglected in Hoffman's review contradicted the above mentioned finding that sex differences did not extend to cognitive empathy. Hall (1978) found that females across all ages significantly outscored males in their ability to recognize another's affect through nonverbal visual and auditory cues. While Eisenberg and

Lennon (1983), in their review of these studies, did not find the evidence as compelling as did Hall for the superiority of female children's visual decoding abilities, they did uphold Hall's findings concerning the adult population as well as female superiority in nonverbal auditory deciphering independent of age. Thus, the literature does indicate that sex differences in empathic abilities exist from childhood on and these differences may encompass both affective and cognitive empathy.

The inconsistencies in the findings concerning sex differences and empathy appear related to the varying methodologies used. Eisenberg and Lennon (1983), primarily using meta-analyses of relevant research studies, found no significant differences in empathy responses of adults when physiological measures were used, or in children when unobtrusive observations of nonverbal responses to others' distress were taken. They found a positive correlation between the demand characteristics in the experimental situation and the size of the sex discrepancy in self-reports of empathy. The most pronounced gender difference for both children and adults was found when self-report questionnaire scales were utilized. The authors suggested that the females' higher endorsement of empathy was syntonic with gender identity, as it has been stereotyped as a feminine trait.

The few studies located comparing global empathy differences in psychotherapists across genders yielded discrepant results among both students and practicing clinicians. Abramowitz, Abramowitz, and Weitz (1976) sampled a class of ten male and eight female graduate student psychotherapy trainees with thirty hours of past supervision both prior to and following a semester practicum. The subjects originated their own responses to videotaped client role plays. The authors found that while with training both sexes improved in their empathic responsiveness, female trainees were judged to be more facilitative than their male counterparts both before and after training, although the latter did not reach statistical significance. These results were replicated on an equivalent sample (Abramowitz, Abramowitz, & Weitz, 1976). However, an analogue study by Breisinger (1976) showed no gender difference in the level of empathic responding by graduate counseling students to videotaped client stimuli. Similarly, using a large sample, 71 females and 102 males, of master's level practicing counselors responding via multiple choice answers to videotaped client role plays, Petro and Hansen (1977) found an equivalence of cognitive empathic judgments between the genders. Contradictory results were found by Sweeney and Cottle (1976) in their comparison of counselors' and noncounselors' ability to accurately judge

a person's emotional state from a photograph. Not only were the female counselors more apt to detect the target's affect than the male counselors, but the male therapists were also outscored by the female noncounselors. Consolidation of these research findings does not provide clear support for the notion that female therapists are on the whole more empathic than their male counterparts. The greatest difference is found in relation to the task of judging the emotion portrayed in a photograph. The generalizability of this finding to therapy assessments is questionable, due to the limited cues engendered from a static picture, as opposed to the multiple channels of input available in an interview. Consequently, there is a vast difference in the operative information base and the attendant processes of integrating stimuli to arrive at an understanding of a person's current state. At best, the above studies suggest that if there is an inherent female empathy advantage, this difference is attenuated through counselor training.

The variable of sexual similarity between therapist and client has also been considered for its impact on the offering of empathic understanding within the counseling dyad. Allport (1937) contended that gender was a relevant personality variable in that understanding was greater within gender as opposed to across gender. This idea is still being advanced today. Dalton (1983) suggests that

differences in traditional culturally induced experiences between the sexes makes the degree of achievable phenomenological understanding greater in same sex pairing. Thus, the capacity for empathy is thought to be supposedly greater in same gender pairs. Feminist therapists echo this sentiment when they advocate that because of a shared sex-role socialization female therapists are better able to understand the subtleties of their women clients' experiences (Tanney & Birk, 1976).

The empirical literature addressing the subject of sexual similarity is somewhat spotty, hitting a variety of populations; it is also methodologically flawed in that sex of subject and target are often not crossed. This contributes to the inconsistencies found in the studies to be reported and also prohibits the drawing of sound conclusions.

Research on gender differences in children's empathic ability have included infants' reflexive crying in response to another infant's distress, while with older children identification and emotional responsiveness to pictures or story stimuli have been used. While meta-analysis of both groups of studies have shown greater responsiveness on the part of females, they were both confounded by the sexual similarity variable (Eisenberg & Lennon, 1983). Five out of seven of the infant studies used female cry stimuli, and the studies utilizing the

picture-story technique relied upon female administrators despite a significant interaction of sex of subject and sex of experimenter factors. These studies are often touted as showing an empathy advantage for females extending back to the cradle; however, it is unclear if this statement is accurate or if gender similarity accounts for a significant proportion of the variance observed.

The possible importance of gender matching effects is highlighted in the studies (Cartwright & Lerner, 1963; Dalton, 1983; Hill, 1975; Howard, Orlinsky, & Hill, 1969; Olesker & Balter, 1972; Petro & Hansen, 1977) which found equivocal differences in empathic responses when comparing sex of therapist across all subjects, but significant interaction when including the sex of client variable. Drawing from a population of undergraduate students, Olesker and Balter (1972) used 96 subjects equally divided between the sexes, with each subject viewing and responding via a multiple choice format to four male and four female videotaped clients. While the sexes were equally able to identify the emotions of the clients viewed, both genders were significantly more accurate in their perceptions when responding to same sex clients. Dalton (1983) also looked at undergraduate students, 10 male and 41 female, and collected independent male and female trainer ratings via a modified Barrett-Lennard

Relationship Inventory (1962) both prior to and following a fourteen week course on interpersonal relationships. He found that while females were rated as tending to be slightly more empathic, congruent, and able to offer unconditional positive regard than males, at neither rating period did these differences reach a level of significance. However, the ratings differed according to the sex of the co-trainer, and they concluded that there "existed sex-specific interpersonal communication patterns . . . [in that] males, and perhaps females to a lesser degree, are perceived as displaying higher levels of interpersonal skills when relating to the same, rather than the opposite sex" (p. 203).

The variable of gender matching has also been shown to be influential in the trained person's ability to understand and select appropriate reactions to affective interchanges. One in vivo study (Cartwright & Lerner, 1963) found that during the initial stages of therapy, counselors were more empathic with opposite sex rather than same sex clients. However, they found that this effect decreased over the course of therapy, and counselors were able to offer equally high levels of empathy to clients of both sexes as they came to know them more. A higher level of empathic responding to same sex clients was found by Hill (1975) in his investigation of actual therapy behavior by practicing counselors.

Similarly, the higher degree of emotional sensitivity and responsiveness found in female, as opposed to male, therapists in Howard, Orlinsky, and Hill's (1969) naturalistic study may have been a function of gender matching, as all of the clients were female. The finding of Petro and Hansen (1977) further complicates the picture by highlighting the influence of client gender alone. They studied master's level practicing counselors, 71 females and 102 males, using a videotaped format with multiple choice responses. While finding a nonsignificant effect concerning emotional sensitivity with respect to therapist gender, they did not find the expected interaction of sex pairing on the accuracy of cognitive empathic judgments across a number of affects, but they did find that both male and female counselors were more sensitive to male client affect than to female client affect. Schwab (1974) also found that counselors of both sexes were more sensitive to male, as opposed to female, affect.

It is clear that the literature does not permit a clear understanding of the influence of gender variables on empathic understanding. Mogul (1982), in her review of the influence of therapist gender on therapy, reported that while same sex dyads can provide the therapist a base of similar experience from which to empathically understand the client, she cautions that reliance on

similar gender experience invites simplification, overidentification, and projection by the therapist. While reporting that the literature on gender effects is inconclusive, she emphasizes the need for training therapists to both engage in therapy with clients of both sexes and to experience supervision with males and females to expose and limit gender determined misperceptions and countertransference. The importance of gender effects may depend on the type of therapy employed. Mogul (1982) concluded that while the sexual composition of the dyad impacts on the order of content and conflicts explored in therapy and the type of alliance formed in brief therapy, therapist gender is generally less influential than experience level and personality in long term insight-oriented treatment, wherein the transference is addressed and examined. Given the increasing necessity of brief therapy, further research on the influence of gender matching and empathy seems warranted.

Gender and Intervention Style and Outcome

Intervention styles of therapists have been shown to differ by therapist gender. Two dimensions of therapeutic style identified in the literature are the degree of affective distance maintained with the client and the level of activity undertaken by the therapist during the session (McNair & Lorr, 1964; Sundland & Barker, 1962; Wallach & Strupp, 1964; Wogan & Norcross, 1983). An

intrusive style defined as being direct, structuring, and self-disclosing in therapy, characterizes self-reports of male therapists, while female therapists more frequently report remaining more distant in therapy and focusing on transference and analysis of resistance in therapy than do males (Wogan & Norcross, 1985). Similarly, two other reports in the literature (McNair & Lorr, 1964; Wogan & Norcross, 1983) found female therapists tended to be more distant, detached, and objective in therapy than male therapists, who valued therapist warmth and affective availability as curative factors. However, McNair and Lorr's (1964) study of 265 therapists reached very different conclusions concerning therapist roles in actively structuring therapy, with males tending to be more nondirective and client-centered than their female counterparts. The authors hypothesized that the resultant sex differences may have been a function of either training, as the females were mostly social workers, while the males were psychologists, or the primarily male client population. The same sex pairing may have been linked to this differential therapist response.

Review of the literature shows a preponderance of analogue studies, while examination of actual sessions suffers from small sample sizes and equivocal findings concerning the impact of client-counselor gender pairings and therapeutic outcomes. Comparing two investigations

utilizing actual case data, we find contradictory results. Scher (1975) analyzed audiotape recorded sessions for 36 counseling center clients, with 23 different counselors rated high on nonpossessive warmth and congruence, and found female counselors to be more verbally active than the males. More experienced therapists were found to be less active in therapy, and their clients reported significantly greater symptom relief and satisfaction with therapy. However, Scher (1975) reported that neither the sexual composition of the counselor-client dyad nor the sheer verbal activity of the counselor significantly effected either client or counselor assessed therapeutic outcome. Howard, Orlinsky, and Hill (1970) found that female outpatients felt more relieved and were more satisfied with therapy when the therapist was female. However, Fuller (1963) found that while female clients tended to express feelings more than male clients, opposite gender pairing appeared to be enhancing for increasing male expression of affect, as having a female in either role in the counselor-client dyad was associated with greater expression of client feeling. While many hypotheses have been formulated as to how therapist gender effects the process or outcome of therapy, the various findings are often not replicable, and thus this area does not offer consistent, generalizable findings to report.

Research on the effects of gender pairing on both style of response and eventual therapeutic outcome has been neither comprehensive nor consistent in its quality. Maracek and Johnson (1980) point out that the influence of gender pairing on the process of therapy has basically neglected the fertile ground of couples, group, and family therapy and has stayed within the confines of adult individual psychotherapy. Additionally, Orlinsky and Howard (1980) offer that even the relevant investigations of gender pairing and outcome within the context of individual therapy have been meager. These latter authors were able to locate only 24 such studies and underscored the fact that many of these did not address the issue of gender matching effects in the basic structure of the research design, but only commented on them as post hoc, incidental, and indirect findings. They suggest that the significance of gender in therapy outcome may be in its interaction with other variables such as diagnosis, age, marital, and parental status and that further study is called for in this area.

Reporting on their findings in just such an investigation of 147 female clients, Orlinsky and Howard (1980) commented on an overall nonsignificant trend for improvement when treated by a female therapist. However, examination of subcategorical groupings showed significant improvement on outcome measures when female therapists

were involved with single women clients or female clients diagnosed as having anxiety reactions or schizophrenia. Outcome ratings showed it was advantageous to have a male therapist if the client was a single mother.

Seeking to add a report of substance to the literature on the relationship of gender pairing to therapy outcome, Jones and Zoppel (1982) reported on two studies of therapist rated patient characteristics and therapy outcome data. One study consisted of a sample of 160 neurotic, affective, and personality-disordered clients from several outpatient facilities covering all socioeconomic levels, who were seen for a minimum of eight sessions in a gender-crossed factorial design. Therapists paired with same gender clients had greater expectations following the initial sessions concerning the probability of client improvement through therapy; they also enjoyed their clients more. Female therapists were more charitable and positive in describing their women clients than were male therapists, who were critical and emphasized female weaknesses as opposed to competencies. The therapist gender assessment discrepancies did not appear as strong in relation to male clients, who were primarily perceived as distant. Outcome measures showed that the female therapists saw their female clients as having benefitted from treatment through symptom reduction more than their male clients. Apart from the

client-therapist gender effects, female therapists saw their clients as progressing more in therapy on both a surface symptomatic level and a deeper characterological level than male therapists did.

The second study focused on the client's perceptions of therapy and utilized 99 former outpatients. There were two significant gender effects. Same gender matched pairs remained in treatment longer, and clients treated by females were able to predict what therapy would have to offer them. Interestingly, therapist outcome ratings from the previous, larger study showed that female therapists felt they had a better therapeutic alliance with their clients than male therapists, and this smaller study showed that both sexes of clients felt that female therapists were warmer, more accepting of, and respectful of the client than male therapists. There is a significant and positive correlation between therapeutic alliance and effectiveness; this study suggests that these female therapists were more capable in this respect than male therapists. How generalizable this finding is is questionable.

Jones and Zoppel (1982) reported that clients in same sex pairs found their therapists to be more nondirective than clients from opposite sex pairs. Female matched pairs appeared to be particularly effective in that clients from these dyads reported that therapy was an

emotionally intense experience, and emotional intensity is positively correlated with positive outcome. The authors suggested that the culturally reinforced characteristics of nurturance and emotional responsiveness, as well as an empathic sensitivity to others' feelings of inadequacy and vulnerability, combine to make women better at forming therapeutic relationships in general and specifically more responsive and able to involve female clients who tend to feel depreciated. While these studies demonstrated clear gender effects on therapy, the relationship between characteristics is complex and they show only relative differences in effectiveness among therapists' performance at a high level of competency.

Gender and Experience Level

Four studies have examined the therapist variables of gender and experience level (Cartwright & Lerner, 1963; Hill, 1975; Kirshner, Genack, & Hauser, 1979; Orlinsky & Howard, 1980). These investigations were naturalistic, involving actual counseling sessions. The earliest study (Cartwright & Lerner, 1963) found that experienced therapists were able to offer high levels of empathy to same sex clients, while novice counselors achieved this level of understanding with opposite sex clients. Subsequent research (Hill, 1975) did not support these results. This later investigation found that counselors overall were able to be more empathic, supportive, and

emotionally responsive with same sex clients. Furthermore, the experienced clinicians felt a lower level of anxiety with opposite sex clients than did the inexperienced therapists. Concentrating on the style of therapy, Hill (1975) found the novice counselors to be directive with same sex clients, while the more seasoned practitioners remained active and directive in opposite sex pairings. Interestingly, both groups of counselors tended to be more active and directive with female as opposed to male clients.

Hill (1975) also looked at the effects of gender pairings and counselor experience level on the dyad's satisfaction with the session. Although male and female counselor groups did not differ in their level of expressed empathy and understanding, clients paired with female therapists were more satisfied with their sessions than those who had male therapists. The author suggested that expectations of nurturance from female counselors and the reception of both nurturance and competence may underlie this finding. Behaviors in female matched pairs could be differentiated by the experience grouping. Inexperienced female therapists were hesitant, less genuine and self-disclosive, and more technique oriented. Experienced female counselors were more emotionally available, and their clients indicated higher satisfaction with the sessions. The differential sensitivity to

therapist experience level may reflect socially derived sex differences in confidence, with males being much more ready to see themselves as competent, while females require more experience before they alter their self-image to include a perception of themselves as capable authorities. While the experienced females were more satisfied with their performance and more able to communicate facilitatively, the more practiced males were both less therapeutically effective and less satisfied with their sessions.

A retrospective study concerned with patient satisfaction with the results of therapy was conducted by Kirshner, Genack, and Hauser (1979). They received questionnaire responses from 189 clients who had been paired with one of 17 male or 5 female clinicians. The experience groupings were meaningfully differentiated, with senior therapists having greater than ten years experience and junior therapists having between two to five years of clinical work behind them. Clients' ratings of satisfaction did not differentiate between the female clinicians of either group and they were equally high for the senior male therapists; however, there was a markedly lower satisfaction rating by clients paired with junior male therapists. Orlinsky and Howard's (1980) investigation obtained similar results when looking at improvement rates. This study defined junior therapists

as having between two and six years of clinical experience, while senior staff had been practicing for more than seven years. Analyzing outcome data on 147 female clients paired with ten female and sixteen male clinicians, these authors found that the senior male therapists were effective, as were the female counselors, irrespective of experience level, while the novice male clinicians lagged far behind in their effectiveness with female clients.

These findings are interesting in themselves, but their somewhat contradictory nature does not readily lead to a more comprehensive, integrated understanding of the interrelationship of these variables. Further attempts at replication are needed to separate the consistent from the idiosyncratic findings. The variables may be too broad in scope and future investigators may find that refinement of research questions including style of approach in therapy along with the gender and experience categories may lead to more stable and informative results.

Gender and Client Affect

The impact of client affect and the sexual composition of the dyad on therapist response style has been investigated in an explorative fashion. It has been hypothesized that, due to socialization patterns, females are most comfortable responding to clients who express sadness and dependency and invite the therapist to respond

nurturantly, and are most uncomfortable with clients who behave in a hostile fashion, while males are more comfortable with clients expressing anger and frustration as opposed to dependency needs (Johnson, 1978). Haccoun, Allen, and Fader (1976) report on an analogue study that partially supports this hypothesis. They looked at the impact the sex of subject, sex of counseling target, and emotional expression of the target (anger, sadness, and neutrality) had on the types of responses undergraduate psychology students offered their peers. While the subjects were able to be facilitative and explore sad affect, they reacted judgmentally to the angry client and thus curtailed examination of the issues and possible coping strategies. The authors found that male subjects perceived the sad female client and the angry male client as less conflicted than the respective opposite sex client expressing the same emotion. However, female subjects' assessments of underlying conflict were not effected by the target sex; they rated the sad targets as more adjusted than the angry clients, independent of their sex. Sex of target appeared to be more of an influence on male subjects' responses. The authors noted that, irrespective of client affect, female subjects were more nurturant than male subjects who, while being benign in responses, were just not as actively facilitative as the females.

Therapists are said to be most disturbed by clients who express cross gender affect (i.e., an angry female or a sad male). However, an in vivo study of 19 therapists treating 28 women patients by Howard, Orlinsky, and Hill (1969) found that the female therapists felt more distressed and embarrassed than their male counterparts in response to the excessive expression of dependency by these clients. Results from previous studies concerning sex and affect interactions have been somewhat mixed, but this may be due to methodological inadequacies and small sample sizes. While Johnson (1978) did not find significant gender by affect interactions among the response of therapists to hostile and depressed clients, each subject responded to only one of four possible tapes. Even with this limited data sample counselors showed differential trends in response to cross sex matchings. The female counselors reacted most negatively to the hostile male, while the male counselor was most facilitative with the hostile female. Langberg (1976) found that counselors approached therapist-directed hostility of opposite sex clients significantly more than same sex clients. This cross gender effect was not found when hostility was directed at others. However, these results are based on only six therapists.

Gamsky and Farwell (1966) looked at the variables of counselor sex, client sex, and counselor response to

hostility. These authors found that while the variable of counselor sex did not significantly effect the therapist's response tendency, client sex did impact on the counselor's response. In particular, therapists were more facilitative in response to male hostility as opposed to female hostility. It can be recalled that two studies (Petro & Hansen, 1977; Schwab, 1974) similarly found that therapists were more sensitive and accurate in response to male rather than female affect.

Cross gender effects were found in Rappaport's (1976) study which used only male clients. He found male therapists were less empathic toward hostile as opposed to friendly male clients. Female therapists were equally facilitative to hostile and nonhostile males. Across clients the females were warmer, more empathic, and more genuine than the male therapists. However, this latter finding may have been a result of the cross sex pairing. The inclusion of female clients would have eliminated the confusion in interpretation.

Considering the cross of gender and affect, it is important to recall the analogue study by Keren-Zvi (1980). He analyzed the responses of 50 male and 50 female psychodynamically-oriented psychotherapists to four clients, wherein he crossed neutral and hostile conditions. While client affect did not significantly effect the level of empathic responsiveness shown by

therapists of either sex, there was a tendency for therapists to choose more counterhostile responses with hostile clients and more avoidant responses with the neutral client. These tendencies were shown by both male and female therapists. The data were not analyzed with regard to the impact of client sex. Therapist gender comparisons showed that while client affect did not effect empathic responsiveness, female therapists consistently offered a higher level of facilitation than male subjects. Keren-Zvi (1980) partially explained this finding by citing correlations between affective empathy and feminine sex-role identification, stating that this linkage supports the ". . . formulations that females have a more highly developed capacity for emotional empathy than males" (pp. 117-118).

## Summary

This chapter began with an attempt to understand how a person develops a hostile or dependent character style. Hostility arises in response to feelings of helplessness associated with deprivation and other injustices and to hide an overwhelming sense of inferiority. Fearing humiliation and rejection, the hostile person's animosity protects a highly vulnerable and anxiety ridden self through projection of his own self-loathing.

Managing hostility in therapy is a key issue and the counselor must be prepared to explore it. Unfortunately,

the therapist is often unnerved by a client's antagonistic stance because of his own unresolved issues. Objective countertransferential responses of avoidance and reciprocal animosity toward hostile patients were documented earlier in this review. Therapists have been shown to have particular difficulty with hostility directed at them as opposed to ire directed toward others. There is some indication that greater experience may dilute this effect; however, the research in this area is meager, consisting of only three dated studies that had somewhat contradictory findings.

The dependent personality was utilized as a contrasting style whereby vulnerability, feelings of inferiority, and fear of rejection/abandonment are defended by self-abasement and compliant submission to a more dominant figure. Self-esteem is maintained by external sources for both hostile and dependent individuals, relying upon achievement with external recognition and other bestowed approval, respectively. While more overtly hostile characters are attempting to avoid recognition of dependency/affiliation needs, dependent persons acknowledge their need for nurturance while attempting to suppress and disavow their anger and hostile reactions. Typical nontherapeutic responses to dependent clients include both distancing from the intensity of their needs and reinforcing their reliance

upon a strong other through adoption of a directive approach with them. The paucity and contradictory nature of studies focusing on differential responses to therapist-directed versus other-directed dependency expressions make it impossible to offer any conclusions regarding such counselor behavior.

Delineating a facilitative therapeutic stance was also a focus of the literature review. Client-perceived empathy appears to be a universally agreed upon characteristic of an effective therapeutic relationship. It is positively correlated with the amount of self-exploration engaged in by the client, as well as with eventual therapeutic success. Some evidence was presented indicating that more experienced counselors are also more empathic.

Two different types of empathy were discussed, cognitive empathy--the ability to understand another's position, and affective empathy--an internal reverberation with another's emotions. Cognitive empathy is thought to be more of an asset in therapy than affective empathy, as experience of another's intense feelings can result in withdrawal from the client rather than communication and exploration of the affect.

Included in consideration of the therapist mediated variables that effect the counseling process, was a general overview of the two schools of thought concerning

countertransference. The traditional group contends that countertransference springs from the counselor's own unresolved infantile conflicts and requires excision, while the neoanalysts suggest that it is triggered by the patient's conflicts and can be utilized to abstract knowledge of the client's emotions and defensive structure. Evidence presented earlier in this review offers some support for this latter notion that there are specific reactions elicited by certain character types. The more empathic counselor has a greater awareness of his own internal response to the client and is more likely to process this information than to blindly react because of the stirred emotions. Theoretical formulations have specifically suggested that responses based on unprocessed countertransferential reactions to hostile clients occur among therapists with the following personality makeup: low in cognitive empathy, high in trait anxiety, high in hostility, and high in need for approval. Three studies have attempted to measure the relative impact of various combinations of these personality variables in response to hostile clients with mixed results. None of these studies have included measurement of the counselor's empathy level.

Information on the contribution of therapist experience level on response to hostile and dependent clients was provided to ascertain if increased exposure

and general seasoning as a professional differentially attenuated initial response difficulties with these character types. Unfortunately, the studies concerning the impact of experience rating on therapists' ability to handle client hostility have suffered from a noticeably restricted range of experience, as they usually only involve counselors in various stages of their training programs. Novice counselors do appear to be negatively effected by client hostility, and the few studies cited earlier that included the genuinely more advanced practitioners suggest that this effect does not dissipate with further clinical practice. Comparisons of therapists' ability to respond appropriately to dependent as opposed to hostile clients generally show an advantage for the former. While experience has been shown to correlate positively with utilization of effective interactions with dependent clients, only four such studies could be located and they do not provide substantial proof to permit such a generalization. Further understanding of the impact of clinical experience on treating hostile and dependent clients could be engendered by eliminating a general experience grouping in favor of a specific measurement of amount of treatment engaged in with the particular character type.

Gender was another factor considered in the review. While in the past clients of both sexes tended to prefer

male counselors, the current trend is that clients' specifically requesting a therapist's gender do so based on the belief that practitioners of the chosen sex are better able to understand the particular issue they are seeking treatment for.

The literature presented found some evidence that the general female population tends to score higher in both cognitive and affective empathy than males. However, the results varied across methodologies, and thus cannot be said to clearly support the often touted theoretical assumption that females have a greater inherent capacity for empathy than males. Attempts to quantify this notion of a female empathy advantage among trained counselors have resulted in contradictory findings. It is unclear if the training process itself eradicates any initial differences or if the lack of specificity of client diagnosis, client sex, and gender pairing variables have obviated the discerning of significant results. Inclusion of gender pairing variables in more complex designs has shown promise, often with counselors being more empathic and nondirective in same sex dyads, yet substantial research is lacking in this area.

Gender pairing effects may also be impacted upon by attributes of the client, especially the client's affect. Specifically, it has been suggested that female therapists are more comfortable with client dependency and less

comfortable with client anger, while the reverse preference is found for male counselors. The results appear to be further mitigated by the client's sex, with displays of cross gender affect (angry female or sad male client) effecting the ability to proffer facilitative interventions. The more recent studies concerning client hostility have attempted to differentiate therapist response tendencies toward anger directed at the counselor from anger directed at others outside the therapy situation. While more able to approach facilitatively in the latter situation, even this seems to be effected by the gender composition of the dyad. Yet the studies in the area of client affect lack both the methodological rigor and consistency of findings needed to make conclusive statements.

Therapist experience level was added as a factor to four of the studies looking at gender pairing effects on perceived empathy, intervention style, and client satisfaction. While there was a tendency favoring same sex dyads and female therapists in general, the number of contradictory findings among these studies does not permit any but the most tentative of statements and advocacy of further research to clarify the interrelationships.

The present study looked at the effect on therapist response of the above mentioned factors: client affect, client and therapist gender pairings, therapist experience

with hostile and dependent clients, respectively, and counselor personality variables including anxiety, hostility, need for approval, and cognitive and emotional empathy. The variables were looked at in a comprehensive fashion to determine their relative influence on the nature of the counselor's response to clients presenting in an antagonistic as opposed to a supplicating posture. Sorting through the relevant factors' impact on therapists' response to hostile clients was the primary focus of this investigation. The inclusion of the dependent clients provided comparison of clinicians' responses to a vastly different type of client. The variables focused upon in this study have been considered in isolation and in various combinations in previous investigations; however, nowhere have they all been considered for their relative influences on the therapeutic interchanges with hostile clients. This study provided the logical next step in this line of research by considering these factors cumulatively.

## Research Hypotheses Stated in Null Form

Hypothesis I. There will be no interaction among any levels of the variables: client affect, sex of client, sex of subject, and response style.

Ia. There will be no difference in subject response style endorsements between hostile and dependent clients.

Ib. There will be no difference in subject response style endorsements between male and female clients.

Ic. There will be no difference in the response style endorsements of male and female subjects.

Hypothesis II. There will be no interactions among any levels of the variables: target involvement, client affect, client sex, and sex of subject.

Hypothesis III. The empathy variables will not account for the significant variance in the response style endorsements.

# CHAPTER III
# METHODOLOGY

## Subjects

Forty-two voluntary subjects were recruited from graduate programs in counselor education, counseling psychology, and clinical psychology, as well as internship training programs. Both male (N=20) and female (N=22) subjects were sought, as previous studies have reported that counselor sex effects response to hostile clients (Keren-Zvi, 1980; Langberg, 1976; Rappoport, 1976). The subjects were recruited from the previously mentioned programs at the University of Florida and Boston University. The student directories of these programs were utilized and subjects were individually contacted by the experimenter to request participation in this study. The order of contact of subjects was randomly determined. Prospective subjects were telephoned by the experimenter and asked to participate in an analogue therapy study. It was explained that the study focused on the relationship among therapist personality attributes, amount of counseling experience, and the therapist's responses to various clients. The experimental protocol was then described. Potential subjects were told that the study consisted of the following: completing a questionnaire describing

their traits, attributes, feelings, and behaviors; viewing four 12-15 minute videotapes of actual clients in initial therapy sessions and responding to their clients as though they were the therapist involved in the interview situation; filling out a data sheet reflecting their amount of actual clinical experience. All those contacted were informed that participation in the study required a two-hour time commitment from them, that this involvement was voluntary in nature as no form of compensation, monetary or otherwise, existed, that group data would be analyzed, and that their anonymity and confidentiality would be maintained within the limits of the law. There was a very low refusal rate among the prospective subjects contacted.

While the actual sample consisted of subjects from age 23 to 65, the majority of subjects were in their mid-twenties to late-thirties. Of the 42 recruited subjects, 20 were enrolled in master's level counselor education programs. The 22 remaining subjects were in Ph.D. programs with 6 such individuals specializing in counseling psychology and 16 in clinical psychology.

The sample's range of supervised practicum experience extended from one to ten semesters. Nineteen subjects were enrolled in courses and completing their practica, while 23 subjects had finished the academic portion of their program and were on internship at the time of their participation in this study. The range of individual

clients treated by this graduate student sample was large, stretching from 2 to 800. Division of this range of client experience indicated that 12 subjects had treated between 2 and 20 clients, 17 subjects had treated between 21 and 50 clients, 5 subjects had treated between 51 and 75 clients, and 8 subjects had treated between 100 and 800 clients. The range of subject experience with overtly hostile and overtly dependent clients were each extensive, 0-300 and 0-150, respectively. The breakdown of the sample's experience with overtly hostile clients was as follows: 4 subjects indicated no such experience; 17 subjects had treated between 1 and 5 such clients; 5 subjects had treated between 6 and 10 such clients; 4 subjects had treated between 11 and 15 such clients; 5 subjects had treated between 16 and 20 such clients; 7 subjects had treated between 25 and 300 such clients. The following distribution of experience among the sample was found regarding overtly dependent clients: 1 subject indicated no such experience; 13 subjects had treated between 1 and 5 such clients; 6 subjects had treated between 6 and 10 such clients; 4 subjects had treated between 11 and 15 such clients; 6 subjects had treated between 16 and 20 such clients; 12 subjects had treated between 21 and 150 such clients. This sample represented a broad range of experience among novice therapists.

## Instruments

### Tape Recordings of Simulated Patients

Two females and two males were hired from the theater department at the University of Florida to role play clients in a simulated initial interview with an experienced therapist. Each actor completed two 20-minute videotaped interviews, once portraying a hostile client and once a dependent client. They had received character sketches outlining the feelings, behaviors, interpersonal dynamics, and self-perceptions characteristic of the client types they were to portray. Presenting problems among the clients were similar; they all involved interpersonal difficulties, focusing either on problems within a present romantic relationship, or with friends in general. Recorded interviews were not scripted. The expertise of the actors was relied upon to breathe life into the role, as it was felt that a spontaneous interaction would increase the credibility of the session for later viewers. Videotaped portrayals as opposed to audiotaped sessions were chosen to provide the subjects with a more complete stimulus to respond to. Videotapes were preferred over live performances, as they insured uniformity in the stimulus materials and were more cost-effective than repeatedly reengaging the services of the actors.

The eight 20-minute tapes were reviewed and the more convincing performance of each actor was chosen. Decisions regarding the performances to be retained for inclusion in the study were made by the experimenter after consultation with a licensed psychologist and advanced graduate student, who reviewed the portrayals. Criteria utilized for performance choice was the congruent opinion among the three judges that the role play more closely resembled the intended characteristics of the client. The performances of three actors resulted in clear cut choices by this method, while in one case the performances were judged to be equally credible, and the decision for role play inclusion was made with respect to the affect category as yet unfilled for that client sex. The four tapes to be used in this study consist of a hostile female, a dependent female, a hostile male, and a dependent male. These four tapes were edited, removing much of what the therapist said during the interview, while leaving those comments which contributed to the understanding of the session. Each tape is divided into ten segments. After each segment the subjects were asked to indicate which response they would prefer to use if they were the therapist in this situation. They were provided with three response choices and asked to rank order the three choices. The transcripts of these four tapes can be found in Appendix D.

Results from the pilot data confirmed that the female actor/clients did indeed portray distinct hostile and dependent clients as intended. After viewing each videotape the 38 subjects in the pilot study completed a checklist of 128 phrases indicating those which the subjects felt could be used to describe the client. The Interpersonal Checklist (Form IV) (Leary, 1957) was the instrument used in this rating procedure. This checklist reflects a circumplex mode wherein the four quadrants represent four different types of behavior: hostile competitive, passive-resistant, support-seeking, and supportive-interpretive. The female hostile client was perceived as hostile-competitive and rated highest on characteristics belonging to the hostile-dominant quadrant by 30 of the 38 subjects. The female dependent client was perceived as support-seeking and received the highest rating on the affiliative-submissive quadrant by 32 of the 38 subjects. All 38 of the subjects rated the hostile client as falling within the hostile half of the circumplex, while viewing the dependent client as belonging within the submissive half of the circumplex. Chi square and Fisher's exact tests showed that perception of the client was not significantly influenced by the subjects' scores on the independent variables.

Initially, all four client tapes were included in the pilot study. However, the sex of client factor was

eliminated and the two male tapes were withdrawn from the pilot study when the subjects complained of fatigue, inability to attend and consistently initiate appropriate responses, and make judgments past the first two sequentially presented tapes. Reduction in demands of the experimented protocol had the desired effect of increasing the motivation and consistency of the subjects. However, consequent to this decision, there were no subject ratings of the male client characteristics on the aforementioned circumplex checklist.

Determination of the validity of the hostile and dependent labels applied to the male tapes was accomplished by having four advanced graduate students in counseling psychology review and rate these stimulus tapes. The ratings of these judges agreed with the experimenter's intentions. Each judge perceived the hostile male as belonging within the hostile-competitive quadrant. Three of the four judges assigned the dependent client portrayal to the support-seeking quadrant, and all four judges saw him as submissive in behavior.

Development of Therapist Response Choices

The categories of moving toward, moving away, and moving against the client were utilized in this investigation. These categories of response style are based on Horney's (1945) theory of interpersonal coping tendencies. Keren-Zvi (1980) used this system in his

investigation of therapist response to hostile and dependent clients and defined the categories as follows:

> "moving toward the patient" is a response which seeks to establish an empathic connection with the patient while addressing the patient's affect; "moving against the patient" was defined as a response expressing the (sic) therapist's hostility toward the patient; "moving away from the patient" was defined as avoidance of the patient's affect by changing the subject, seeking information peripheral to the patient's statement, or any other attempt to diffuse the patient's affective expression. (p. 60)

A multiple choice format was chosen, as it obviates the need for judging subject-created responses, and thereby increases the objectivity of the data and decreases distortion of the data by eliminating the possibility of both stereotypic and amorphous responses being given by the subject. Rank ordering prepared responses from these three categories allows the subject to clearly endorse preferred interpersonal coping styles when confronted with two different client affects. The use of this format had the added benefit of decreasing the amount of time needed to respond to the tapes, making it possible for each subject to respond to the two male tapes as well as the two female tapes originally prepared for this study. This allowed for the testing of gender-affect affects on therapist response tendencies. Preliminary experimentation required subjects to create their own responses to the four tapes; this procedure was

discontinued as the subjects complained of fatigue when asked to formulate their own responses to all four tapes.

Three alternatives, one from each category, were provided for every stopping point on the tape. The tapes had 10 stopping points apiece. The 120 response alternatives were generated in part from the subject formulated responses obtained in the pilot data. These prepared responses were individually coded by three groups of four doctoral candidates in counselor education. Each group was given only one of the three alternatives for each client statement, thus eliminating the contextual influence of the other two choices on category assignment. The criterion for retention of an alternative was the categorical agreement by three of the four raters in line with the intention of the experimenter. Responses which did not reach this criterion level of agreement were revised until acceptable by three licensed practicing Ph.D. level psychologists (see Appendix E). This categorization of therapist response is not only grounded in an established theory (Horney, 1945), but also circumvents some of the problems embedded in the scoring systems utilized by previous investigations. Bandura, Lipsher, and Miller (1960) conducted a similar study and rated responses as either approaching or avoiding the client. As Keren-Zvi (1980) points out, this system fails to differentiate a hostile approach from an empathic one.

The approach-avoidance system was used during the initial training of the raters in the pilot study. The coding of hostile interpretations was highly unreliable and this system was abandoned in favor of the proposed three category system. The refinement of the categorical system was felt to increase the meaningfulness of the data and insure more precise interpretations of the results.

The three categorical system of moving toward, away, and against was used previously in a study of therapist response to hostile patients (Keren-Zvi, 1980). Adoption of this coding system in the present investigation seems most appropriate as this proposed study is an extention of the line of investigation followed by Keren-Zvi (1980).

The moving toward response was subdivided by a target involvement variable into therapist-involved empathic responses and generalized empathic statements. A distinction was made concerning whether the empathic response allowed the discussion to include the potential influence of a therapist and the present interaction on the client's affect, or whether the facilitative response focused on the impact of relationships external to the therapeutic situation. The former category of moving toward response was labeled involved therapist, while the latter was labeled generalized statement (see Appendix E). The validity of this differentiation was established through categorical agreement by three licensed practicing

Ph.D. level psychologists. On each of the four tapes the 10 moving toward responses were composed of 5 involved therapist empathic responses and 5 generalized empathic statements. Thus, data could be collected on the therapists' tendency toward endorsement of empathic responses and whether this tendency was affected by the counselors' willingness to examine the real or transferential impact of the current interaction on the client. This target involvement variable has been shown to be influential in the past studies of empathic responding toward hostile clients (Bandura, Lipsher, & Miller, 1960; Gamsky & Farwell, 1966; Varble, 1968) and dependent clients (Schuldt, 1966; Snyder, 1963).

State-Trait Anxiety Inventory (STAI)

The subjects' anxiety level was measured by the State-Trait Anxiety Inventory, Form Y (STAI) (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983). This questionnaire is divided into two 20-item scales; one measures state anxiety (STAI-S) and the other measures trait anxiety (STAI-T). State anxiety scales measure transitory reactions of apprehension, worry, and heightened arousal of the autonomic system, which are evoked by specific conditions. Trait anxiety scales measure a stable behavioral predisposition to perceive a wide variety of situations as threatening. Zuckerman (1983) outlines the evidence supporting the notion of

differentiation between trait and state scales. He states that while both types of scales show high internal consistency, state measures differ from trait measures in that they are effected by situational variance and show low retest reliability. Also both types of measures correlate more highly with similarly scaled measures of the same construct than with the alternate form of measurement, and thus both state and trait tests show convergent and divergent validity.

Construct validity has been demonstrated for the two scales of the STAI. While the STAI-S anxiety score varies under different conditions, the trait form of the STAI has been found to be impervious to situational stresses. STAI-T scores are stable across experimental manipulations of both arousing and relaxing conditions (Johnson & Spielberger, 1968; Spielberger, Auerbach, Wadsworth, Dunn, and Taulbee (1973). Evidence of construct validity is also presented in the studies of contrasting client groups. Scores on the STAI-T scale have been found to differentiate psychiatric patients from normal subjects in the predicted direction based on the prevalence of anxiety in pathological symptomology (Spielberger et al., 1983). These authors also found that character disordered patients, who are in part defined by their lack of anxiety, had low STAI-T scores.

Only the 20 items comprising the Trait scale of the STAI were included in this study, as the purpose was to measure the impact of a stable predisposition to perceive situations as personally threatening on behavior. It is the effect of anxiety-proneness on behavior and not the level of anxiety triggered by the experimental situation that is needed for the generalization of these results.

The STAI-T anxiety scale items were rated by the respondent on a four-point scale indicating the frequency of occurrence of such feelings, ranging from Almost Never to Almost Always. The STAI was revised in 1980 and it is this revised form (Form Y) that will be used in this study. While Form Y correlates highly with standardized Form X (r=.96-.98), Form Y is an improvement in that the response set is more adequately controlled for, with nine of the twenty items being keyed false. This current form also more adequately reflects the theoretical concept of anxiety as distinguished from depression.

Factor analytic studies suggest that the STAI-T anxiety scale is a unidimensional instrument measuring cognitive anxiety, as 14 of the 20 items reflect worry, rumination, and disappointment (Kendall, Finch, Auerbach, Hooke, & Mikulka, 1976). The STAI-S reflects two other independent factors and thus adds further evidence for the differentiation of the STAI-T and STAI-S scales. The STAI-T has been found to be highly predictive of state

anxiety responses in ego-threatening situations, while being unrelated to state anxiety arising from physically harmful conditions. This has led Kendall et al. (1976) to conclude that the STAI-T scale measures "a cognitive dimension of ego involvement or fear of failure" (p. 407) that is related to fear of a loss of self-esteem.

The STAI-T has demonstrated adequate concurrent validity, as it correlates highly with other widely used measures of trait anxiety. Spielberger, Gorsuch, and Lushene (1970) found a correlation of r=.80 between the STAI-T and the Taylor Manifest Anxiety Scale (TMAS, 1953) for college students and an even higher correlation for neuropsychiatric patients. Similarly, a correlation of r=.75 was found between the STAI-T and Cattell and Scheier's IPAT Anxiety Scale (1961). While correlating highly with both established trait measures, the STAI-T was preferred over the 50-item TMAS and the 43-item IPAT because of the relative brevity of this 20-item scale, as well as its exclusive focus on items reflecting anxiety, as contrasted with the IPAT's inclusion of anger-related items and the TMAS's inclusion of depression-related items. Comparisons among test results from a group of neuropsychiatric patients showed that while STAI-T scores correlate highly (r=.81) with Scale seven on the MMPI (Hathaway & McKinley, 1951) which measures anxiety, the

STAI-T scores are unrelated to intelligence, aptitude, and achievement indexes (Spielberger et al., 1983).

Test-retest correlations of .86 for 20 days and .73 for 104 days have been reported for the STAI-T (Spielberger et al., 1970). While test-retest correlations for a group of 49 medical students for 8 and 11 months were somewhat lower than expected, $r=.54$ ($p<.01$) and $r=.29$ ($p<.05$), respectively, the authors suggest that the restricted nature of the sample and the unique characteristics of medical training may have influenced the results (Nixon & Steffeck, 1977).

Adequate internal consistency has been demonstrated for the STAI-T. Based on a sample of 1800 high school and college students, Spielberger et al., (1970) found alpha coefficients ranging between .86 and .92 for Form X. The alpha coefficients for Form Y are just as high, with Spielberger et al. (1983) reporting a median coefficient across samples of .90. They also report that item-remainder correlation coefficients do not go below. 30 for any of the items of the STAI-T scale when these coefficients were calculated with diverse samples.

Buss-Durkee Hostility Inventory (BDHI)

The Buss-Durkee Hostility Inventory (BDHI) (Buss & Durkee, 1957) was chosen to measure the subject's level of hostility. The BDHI was chosen because it is a psychometrically sound instrument. A major concern in the

construction of a hostility inventory is the confounding influence of social desirability on the subject's response, as the items deal with socially undesirable behaviors. This 66-item inventory was constructed in a manner to minimize the influence of social desirability. The wording of the items minimized defensive responding in two ways: by assuming the presence of the socially undesirable state and asking only for its manner of expression, thus focusing on behaviors and not value judgments, and by using universal stimulus situations and idioms which justified the behavior as a natural and frequent occurrence in the population (Buss & Durkee, 1957). Correlation between the BDHI item endorsement and the scaled social desirability of the items were low but significant at r=.27 for men and r=.30 for women (Buss & Durkee, 1957). While there appears to be some influence on response direction, social desirability does not appear to be a major contaminating factor of the BDHI. These correlations are significantly lower than the .87 correlation usually found between social desirability and probability of item endorsement (Edwards, 1953), and suggest that the item-writing techniques were effective in minimizing the influence of social desirability. Response set has also been taken into account; the ratio for directionality of scoring is four true to one false item.

In their attempts to operationalize the definition of hostility Buss, Durkee, and Baer (1956) found significant correlations (r=.39 for males and r=.54 for females) between hostility ratings from interview situations and scores on the Iowa Hostility Inventory. Although there was a definite relationship between these measures, the experimenters sought to improve the questionnaire method of assessment by identifying the subcomponents of hostility and increasing the specificity of items included in the BDHI. While providing a global hostility score, the 66 true-false items on the BDHI are divided into six independent subscales measuring six different clinical manifestations of hostility. The subscales constructed by Buss, Durkee, and Baer (1956) are assault, indirect hostility, irritability, negativism, resentment, suspicion, and verbal hostility. The items retained for the final scale were uniformly answered by 15-85% of the college sample utilized and demonstrated internal consistency by reaching a biserial correlation coefficient of .40 with appropriate subscale (Buss & Durkee, 1957). Administration of the final form of the scale to 85 male and 88 female college students revealed low inter-correlations among the subscales. Only two correlations for the male subgroup exceeded .50, with verbal hostility and irritability at r=.66 and suspicion and resentment at r=.58 (Buss & Durkee, 1957).

Although test-retest coefficients are not available, a study by Gunn and Gristwood (1975) using British prisoners in repeated administrations of the BDHI, reported that "the instrument had adequate internal consistency and satisfactory short-term stability" (p. 590). Employing a sample of college students, Sarason (1961) found correlations of .50 to .55 between the global hostility score on the BDHI and the aggression scale of the Waterhouse and Child Psychological Insight Test.

Marlowe-Crowne Social Desirability Scale (M-C SDS)

The subjects' need for approval was measured with the Marlowe-Crowne Social Desirability Scale (M-C SDS) (Crowne & Marlowe, 1960). This scale was chosen because it measures a motivational variable, the desire to appear to conform to societal standards, which is a broad band personality characteristic. The items that comprise the M-C SDS are culturally approved but improbable behaviors. The low probability of occurrence ensures that endorsement of the items reflects a need for social approval as opposed to a true reporting of past behaviors. The psychometric rationale underlying the M-C SDS resembles that of the Lie Scale on the MMPI (Meehl & Hathaway, 1946); in fact, the M-C SDS correlates positively with the MMPI validity scales (Crowne & Marlowe, 1960).

A high need for approval is associated with conforming behavior. Concurrent validation of the concept

reflected in the scale is shown in the significant negative correlation ($r=-.54$, $p<.01$, $N=57$) between the M-C SDS and the Barron Independence of Judgement Scale (Barron, 1953), a measure of nonconformity (Marlowe & Crowne, 1961). These experimenters also presented construct validity data concerning the motivational quality of the social desirability variable. Utilizing the spool packing task of Festinger and Carlsmith (1959) as a frustrating task to precipitate socially undesirable responses, they showed that the strength of need for approval, as measured by the M-C SDS differentiated those subjects who expressed favorable attitudes towards this repetitive and frustrating task from those who did not comply with the situational demands and expressed socially undesirable reactions to this task.

The influence of response set is controlled for in the M-C SDS, as eighteen items are keyed true and fifteen items are keyed false. Test-retest correlations over a one-month interval suggest adequate stability in scores across this time frame ($r=.86$ to $.89$, $p<.01$, $N=60$) (Crino, Svaboda, Rubenfeld, & White, 1983; Crowne & Marlowe, 1960). This scale has also been demonstrated to be internally consistent. Split-half reliability estimates have ranged from .72 (Ford, 1964) and .84 (Horst, 1951) to .87 (Crino et al., 1983). Using the Kuder-Richardson

formula 20, an internal consistency coefficient of .88 was found (Crowne & Marlowe, 1960).

The other popular measure of social desirability is the Edwards Social Desirability Scale (E-SDS) (Edwards, 1957). The items for this scale were drawn from the more deviant MMPI items, and thus this scale reflects the degree to which one will admit to psychopathological symptoms. While the E-SDS is a measure of test-taking defensiveness, the M-C SDS is based on a more generalizable definition of social desirability, focusing on "a need for social approval and acceptance and the belief that this can be attained by means of culturally acceptable and appropriate behavior" (Marlowe & Crowne, 1961, p. 109). The M-C SDS correlates negatively with the clinical scales of the MMPI; this 33-item test is not confounded by a high loading of psychopathological content. The independence of these two scales, the M-C SDS and the E-SDS, is reflected in the different methods of item generation and the low interscale correlations (r=.26 to .39) Crino et al., 1983).

Hogan Empathy Scale (HES)

Empathy has been found to have both cognitive and affective components; consequently, a scale measuring each domain has been chosen to estimate the subjects' level of empathy. The Hogan Empathy Scale (HES) (Hogan, 1969) measures the cognitive dimension of empathy, the ability

to understand another's state of mind without internally resonating to the feelings of others. This scale has been said to reflect trait empathy as opposed to situationally stimulated empathy measured by the Truax scales (Haier, 1974).

This 64-item scale is composed of items from the MMPI, the California Personality Inventory (CPI) (Gough, 1964) and the University of California Institute of Personality Assessment and Research (IPAR) testing devices, which correctly differentiated prejudged groups of high and low empathic responders. These groups were rated on the dimension of empathy according to a criterion Q-sort description with high reliability (r=.90) developed by seven psychologists and advanced graduate students, which stressed intrapersonal and interpersonal insight concerning behaviors and motivations, perceptiveness, and social acuity. The resulting scale is based on an analysis of 957 items using contrasting groups with a total of 211 subjects. While this scale was for the most part empirically derived, 17 items were retained on the basis of face validity as opposed to reaching statistical significance. The possible influence of an acquiescent response set is eliminated as the items are balanced for true and false keying. Greif and Hogan (1973) report that factor analysis of the responses of 359 subjects reveals three underlying factors accounting for 12% of the

variable which reflect the following characteristics: tolerant and even-tempered, socially ascendant and outgoing, and having humanistic sociopolitical attitudes. A more recent factor analysis (Johnson, Cheek, & Smither, 1983) resulted in four factors, three of which are highly similar to those just described and were identified as even-temperedness, social self-confidence, and nonconformity, which referred to the rebellious and unconventional attributes of the empathic responder. The additional factor was labelled emotional sensitivity. The latter two factors appear to be slightly more influential; however, in total, these four factors account for only 26% of the variance in response.

Evidence for construct validity is found in the correlation between the scale scores and the Q-sort empathy ratings of the original subjects ($r=.62$) (Hogan, 1969). Correlations between composite ratings of social acuity, focusing on perception and intuitive empathic responses to subtle changes in interpersonal behavior, and the empathy scale score for this sample was .58, while for an independent sample of 70 medical school applicants (Hogan, 1969) this comparison yielded a correlation of .42. Contrasting groups derived from teachers' ratings of 121 junior high school students on social acuity responded in the predicted direction on the Hogan Empathy Scale, $p<.01$ for boys and $p=.05$ for girls (Hogan, 1969). Scores

on the HES have been shown to correlate positively ($r=.86$, $p<.001$) with congruence scores of self and observer ratings of personality traits (Mills & Hogan, 1978). Thus, this scale demonstrates the conceptual notion that empathic individuals have a higher degree of self-awareness and are less likely to engage in distortions of their reality and self-deceptions (Rogers, 1975).

Results of correlations between HES and various personality measures on two separate samples (Hogan, 1969), 70 medical applicants and 51 female college seniors, provide evidence for the convergent and discriminant validity of the scale. Conceptually, according to Mead (1934), one's level of empathy is associated with his degree of social effectiveness, because being able to take the other's role and be cognizant of others' attitudes is a basic skill in social interaction. This theoretical relationship is reflected in the positive correlation ($p<.01$) of scores between HES and the CPI scales measuring social and interpersonal competence (Hogan, 1969). Empathy has also been theoretically linked in a positive fashion to ego strength and in an inverse manner to anxiety (Kupfer, Drew, Curtis, & Rubinstein, 1978). The HES was found to correlate positively with the ego strength scale on the MMPI ($p<.01$) and negatively with the TMAS ($p<.01$ for the medical school sample) (Hogan, 1969). This inverse relationship between

empathy and trait anxiety was also found in a prison population (Andrews, Wormith, Daigle-Zinn, Kennedy, & Nelson, 1980) and among undergraduates when correlating scores on the HES with the STAI-T scale ($r=-.36$, $p<.01$) (Deardoff et al., 1977). It has been suggested (Chlopan et al., 1985; Johnson, Cheek, & Smither, 1983) that the even-temperedness component of cognitive empathy accounts for its negative relationship with emotional maladjustment and anxiety. Similarly, empathy and authoritariansim are negatively related (Hogan, 1975). Comparisons of scores on the HES and the California F Scale (Adorno, Frenkel-Brunswik, Levinson, & Sanford, 1950) show a strong inverse relationship ($r=-.52$, $N=48$) (Hogan, 1969).

A test-retest reliability coefficient of $r=.84$ was found with a sample of 50 undergraduates after a two-month interval. Internal consistency data show moderate scale homogeneity, with an alpha reliability estimate of .71 ($N=100$) in Hogan's (1969) original sample of military officers, .69 ($N=165$) in Johnson, Cheek, and Smither's (1983) factor analytic study, and .61 ($N=95$) reported by Cross and Sharpley (1982).

This scale has been shown to be clinically relevant, as HES scores of the therapist have been found to be positively correlated ($r=.43$, $p<.01$) with successful treatment of hyperactive children, regardless of the treatment approach utilized (Kendall & Wilcox, 1980).

This scale has also been shown to effectively discriminate abusive from nonabusive mothers (hit rate = 80%) in an investigation by Gray (1978) on the relationship of empathy, stress, and child abuse.

Measure of Emotional Empathy (M-E MEE)

The affective dimension was measured via Mehrabian and Epstein's (1972) Measure of Emotional Empathy (M-E MEE). This is a self-report measure that taps the subject's degree of emotional responsiveness to the feelings of others. This scale consists of 33 items which the respondent rates on a 9-point scale indicating the intensity of his endorsement of the item, ranging from +4 (very strong agreement) to -4 (very strong disagreement). Seven subscales tapping associated aspects of emotional empathy underly this scale. These subscales correlate with each other and the total scale score at the .01 level of significance (Mehrabian & Epstein, 1972). Internal consistency of the measure is attested to with a split-half reliability coefficient of r=.85 (Mehrabian & Epstein, 1972). This high level of reliability was also obtained with an adolescent subject population (Adams, Schvaneveldt, & Jensen, 1979). Test construction included an effort to eliminate a social desirability bias in the items of this scale, a successful effort, as demonstrated by an insignificant correlation of r=.06 with the M-C SDS (Crowne & Marlowe, 1960).

Mehrabian and Epstein (1972) sought evidence of construct validity utilizing experiments focused on two distinct situations, aggression and helping behavior. They hypothesized that the degree of emotional empathy of the subjects would be inversely related to their tendency to aggress against victims (i.e. delivery shocks via the Milgram (1965) paradigm) when they could see the victim's distress. The predicted level of interaction between empathy level and immediacy of victim feedback was reported in a study by these authors (N=88). The same tendency was also found in their replication experiment. Subjects in the high empathy group aggressed significantly less when the object of their punishment was within their view, as compared to being hidden in another room, while the behavior of low empathy subjects were not significantly impacted by their proximity to the victim. Mehrabian and Epstein (1972) also predicted that helping behavior, defined as the amount of time they volunteered to aid another in completing a project, would be positively related to level of emotional empathy. Results of their study (N=81) supported this hypothesis. Highly empathic subjects were also shown to be more emotionally aroused by the other's affect. The authors concluded that this measure was a valid measure of the affective component of empathy, as it differentiated those who were

emotionally responsive to other's needs from those who were not.

Similarly, a review of the current research on the M-E MEE (Chlopan et al., 1985) provides further evidence of construct validity with high empathy scorers also, obtaining high scores on another measure of emotionality, neuroticism, having high levels of social concern and awareness, having an external locus of control, being less likely to filter out recognition of minor stimuli, and being more overtly responsive to others' distress. These authors suggest that these separate findings can be subsumed under a factor of arousability which bears out the conceptual notion that those high in affective empathy have lower than average thresholds for emotional contagion from external stimuli.

The Integrated Scale

Items from the five aforementioned scales, STAI-T, BDHI, M-C SDS, HES, M-E MEE, were combined to form a 216-item questionnaire (see Appendix C). The items were randomly assigned to their numerical position within the final scale. Given the population being sampled, it was assumed that the subjects might be familiar with some of the instruments used. Randomization of items was utilized to minimize awareness of the instruments being used and thereby reduce the possibility of related confounding of the data.

While it is possible that combining these scales may affect the reliability and validity of the individual scales, there is evidence that this does not necessarily occur. Spielberger (1979) combined three independent personality measures in one scale and compared the scores of the independently administered scales to their counterparts on the combined inventory. The resulting correlation coefficients were high enough (r=.93 to .99) to minimize concern about the effect of the transformation on the individual scales' established reliability and validity. The positive effect of disguising the scales appeared to outweigh the possible risk of distortion, due to integration of the scales, and the amalgamated form of the questionnaire was chosen.

## Procedure

Subjects were scheduled for a testing time at their convenience. Subjects were tested both individually and in small groups of up to five subjects based on their availability. The subjects first completed an informed consent statement (see Appendix B) reiterating the nature of the study which had been explained during the initial request for participation. Subjects then completed a 216-item questionnaire (see Appendix D), which was an amalgamated scale consisting of five separate inventories: the Buss-Durkee Hostility Inventory (Buss & Durkee, 1957); the State-Trait Anxiety Inventory, Form Y (Spielberger,

et al., 1983); the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960); the Measure of Emotional Empathy (Mehrabian & Epstein, 1972); and the Hogan Empathy Scale (Hogan, 1969).

After Completing the questionnaire, the second phase of the study concerning presentation of the videotapes of simulated clients in individual therapy sessions took place. Prior to viewing the videotapes the subjects received the following written instructions:

> You are about to view a segment of a videotape of a client/patient in an initial therapy session. You are to imagine that you are the counselor/therapist in this therapy session. At various points during the viewing the tape will be stopped and you are to rank order the response alternatives for that segment from one to three. A tone will signal you when you are to respond. After the tone you will have 30 seconds in which to rank order your responses, and then the videotape will resume motion.
>
> Mark a 1 next to the response alternative <u>you</u> would most likely use in that situation, mark a 2 beside the next likely response, and mark a 3 next to the response you would be least likely to use with that client at that point in time. All of the responses are viable alternatives, and there are no right or wrong answers. We are simply interested in which response you would most likely use in these situations.

Each tape was stopped at ten prearranged locations in order for the subject to respond to the simulated client. The same procedure was followed for each videotape. Each subject saw the same four tapes, although the order of presentation of tapes was counterbalanced to alleviate the possible influence of tape position. The subjects were

told that the tapes were segments from actual therapy sessions, as it was thought that this belief would maximize the interest and effort during the testing session.

Following completion of responses to the fourth tape, the subjects filled out the Personal Data Sheet (see Appendix F). This sheet collected both demographic data and estimates of the subjects' level of experience in therapy, as measured by the number of practicums taken, the number of overtly hostile clients treated, the number of overtly dependent clients treated, and the number of clients treated in individual therapy.

The subjects were then debriefed. They were told that the videotapes were simulated therapy sessions and that the study was investigating the differential influence of therapists' personality attributes and experience level on their response tendencies with hostile as opposed to dependent clients. They were then given a brief overview of the theoretical underpinnings of the study and were invited to contact the experimenter to receive feedback on the results of the investigation.

# CHAPTER IV
# RESULTS

## Demographic Data

The sample could be divided in the following ways: by sex, by internship status, and by educational program. The impact of relative status in these groupings on subject personality and experience variables was tested via comparison of the appropriate means. A series of t-tests were conducted comparing the mean scores of male subjects to the female subjects on each of these variables (see Table 1). The results showed no significant differences between the sexes in terms of the reported personality characteristics, hostility, anxiety, need for approval, emotional empathy, or on amount of experience with hostile or dependent clients. There was a nonsignificant trend ($t=1.991$, $p=.053$) for male subjects to score slightly higher on the cognitive empathy self-report measure than their female counterparts. However, given the conservative setting of the significancy level ($p=.0167$) necessitated by the separate analysis of the data for each of the three independent variable groupings, this result did not approach the needed probability level to be considered a statistically significant finding.

Table 1

Means, Standard Deviations, and t-ratios for the Means of Personality and Experience Variables for Male and Female Subjects

| Variable | Males | Females | T | p |
|---|---|---|---|---|
| B-D Hostility Inventory | | | | |
| $\bar{X}$ | 26.400 | 24.364 | 0.814 | 0.420 |
| Sd | 8.858 | 7.333 | | |
| S-T Anxiety Inventory | | | | |
| $\bar{X}$ | 38.050 | 37.773 | 0.114 | 0.911 |
| Sd | 8.763 | 7.158 | | |
| M-C Social Desirability Scale | | | | |
| $\bar{X}$ | 11.350 | 14.182 | -1.737 | 0.090 |
| Sd | 5.092 | 5.439 | | |
| Hogan Empathy Scale | | | | |
| $\bar{X}$ | 45.100 | 41.682 | 1.991 | 0.053 |
| Sd | 5.467 | 5.635 | | |
| M-E Measure of Emotional Empathy | | | | |
| $\bar{X}$ | 41.450 | 49.591 | -1.293 | 0.203 |
| Sd | 21.249 | 19.551 | | |
| Number of Hostile Clients* | | | | |
| $\bar{X}$ | 20.250 | 25.364 | -0.333 | 0.742 |
| Sd | 29.006 | 65.317 | | |
| Number of Dependent Clients* | | | | |
| $\bar{X}$ | 20.700 | 25.182 | -0.448 | 0.656 |
| SD | 28.4032 | 35.568 | | |

*Previous treatment experience with specific client types.

As the sample was almost evenly split on the variable of internship status, with 23 currently involved in or having completed internship and 19 having yet to reach that position, t-tests were run comparing the means of these two groups on the above mentioned variables (see Table 2). Internship grouping differentiated the sample only on the expected variable of experience, with a trend for interns to have seen more hostile clients than preinterns ($t=1.93$, $p=.066$) and having treated significantly more dependent clients ($t=3.00$, $p<.01$).

Separate analyses of variance were conducted for each of the subject personality and experience variables to test for any effect of educational training, as the subjects were enrolled in clinical psychology, counseling psychology, or counselor education (see Table 3). The results revealed that the subjects' educational program did not account for any uniformly varying patterns among the predictor variables of subject personality and experience.

Having determined that the sex, internship status, and educational program factors did not effect the above-mentioned independent variables in any consistent pattern, the decision was made to run the analyses of the data on the sample as a whole. Mean age of the subjects was 31.2 ($Sd=7.566$), with a range of practicum experience from one to ten semesters ($\bar{X}=3.33$, $Sd=2.10$).

Table 2

Means, Standard Deviations, and t-ratios for the Means of Personality and Experience Variables for Intern and Pre-intern Subjects

| Variable | Interns | PreInterns | T | p |
|---|---|---|---|---|
| B-D Hostility Inventory | | | | |
| $\bar{X}$ | 24.217 | 26.684 | -0.987 | 0.330 |
| Sd | 7.804 | 8.367 | | |
| S-T Anxiety Inventory | | | | |
| $\bar{X}$ | 36.478 | 39.632 | -1.304 | 0.200 |
| Sd | 7.464 | 8.187 | | |
| M-C Social Desirability Scale | | | | |
| $\bar{X}$ | 13.391 | 12.158 | 0.732 | 0.469 |
| Sd | 6.236 | 4.259 | | |
| Hogan Empathy Scale | | | | |
| $\bar{X}$ | 43.826 | 42.684 | 0.636 | 0.529 |
| Sd | 5.789 | 5.803 | | |
| M-E Measure of Emotional Empathy | | | | |
| $\bar{X}$ | 40.696 | 51.789 | -1.788 | 0.081 |
| Sd | 21.436 | 18.122 | | |
| Number of Hostile Clients* | | | | |
| $\bar{X}$ | 35.130 | 8.158 | 1.926 | 0.066 |
| Sd | 66.137 | 10.678 | | |
| Number of Dependent Clients* | | | | |
| $\bar{X}$ | 34.522 | 9.158 | 3.00 | 0.006 |
| Sd | 39.204 | 9.424 | | |

*Previous treatment experience with specific client type.

Table 3

Analysis of Variance Summary for Subject Personality and Experience Variables by Educational Program

| Variable | Source | Sum of Squares | df | Mean Square | F | p |
|---|---|---|---|---|---|---|
| B-D Hostility Inventory | | | | | | |
| | Educ Program | 45.763 | 2 | 22.881 | 0.34 | 0.713 |
| | Error | 2617.571 | 39 | 67.117 | | |
| | Total | 2663.333 | 41 | | | |
| S-T Anxiety Inventory | | | | | | |
| | Educ Program | 192.232 | 2 | 96.116 | 1.60 | 0.215 |
| | Error | 2343.388 | 39 | 60.087 | | |
| | Total | 2535.619 | 41 | | | |
| M-C Social Desirability Scale | | | | | | |
| | Educ Program | 156.563 | 2 | 78.281 | 2.93 | 0.065 |
| | Error | 1041.271 | 39 | 26.699 | | |
| | Total | 1197.833 | 41 | | | |
| Hogan Empathy Scale | | | | | | |
| | Educ Program | 105.989 | 2 | 52.994 | 1.65 | 0.205 |
| | Error | 1250.988 | 39 | 32.077 | | |
| | Total | 1356.976 | 41 | | | |
| M-E Measure of Emotional Empathy | | | | | | |
| | Educ Program | 549.101 | 2 | 274.550 | 0.64 | 0.533 |
| | Error | 16751.471 | 39 | 429.525 | | |
| | Total | 17300.571 | 41 | | | |

Table 3--continued

| Variable | Source | Sum of Squares | df | Mean Square | F | p |
|---|---|---|---|---|---|---|
| Number of Hostile Clients* | | | | | | |
| | Educ Program | 3968.015 | 2 | 1984.007 | 0.76 | 0.475 |
| | Error | 101884.771 | 39 | 2612.430 | | |
| | Total | 105852.786 | 41 | | | |
| Number of Dependent Clients* | | | | | | |
| | Educ Program | 4484.621 | 2 | 2242.311 | 2.32 | 0.111 |
| | Error | 37621.283 | 39 | 964.648 | | |
| | Total | 42105.905 | 41 | | | |

*Previous treatment experience with specific client type.

## Findings Related to Hypothesis I and Its Subhypotheses

Hypothesis I focused upon the effects of the variables, client affect, sex of client, and sex of subject on the response style endorsed. The formulation was that there would not be any significant interactions among any levels of these variables. The subhypotheses centered on the impact client affect, sex of client, and sex of subject individually had upon the response styles. A mulivariate analysis of variance (MANOVA) (Winer, 1971, pp. 322-340) procedure was used to test these hypotheses. This technique is particularly suited to the research question,

as it determines whether each independent variable operates differently at the separate levels of the other controlled factors. It yields a separate F statistic for each predictor variable and one for each interaction.

A summary of the relevant results of the MANOVA can be found in Table 4. There was a significant interaction of client affect and the response style variables F(2,39)= 23.46, p=.0001. This interaction is graphically presented in Figure 1. Comparison of the appropriate means comprising this interaction is reported in Table 5.

Table 4

Multivariate Analysis of Variance for Client Affect, Sex of Client, Sex of Subject, and Response Style

| Variable | df | F | p |
|---|---|---|---|
| Response Style-Affect-Client Sex-Subject Sex | 2,39 | 1.36 | 0.268 |
| Response Style-Affect-Client Sex | 2,39 | 1.89 | 0.164 |
| Response Style-Affect-Subject Sex | 2,39 | 1.25 | 0.297 |
| Response Style-Client Sex-Subject Sex | 2,39 | 0.27 | 0.768 |
| Response Style-Affect | 2,39 | 23.46 | 0.0001 |
| Response Style-Client Sex | 2,39 | 1.08 | 0.348 |
| Response Style-Subject Sex | 2,39 | 1.50 | 0.235 |
| Response Style | 2,39 | 185.89 | 0.0001 |

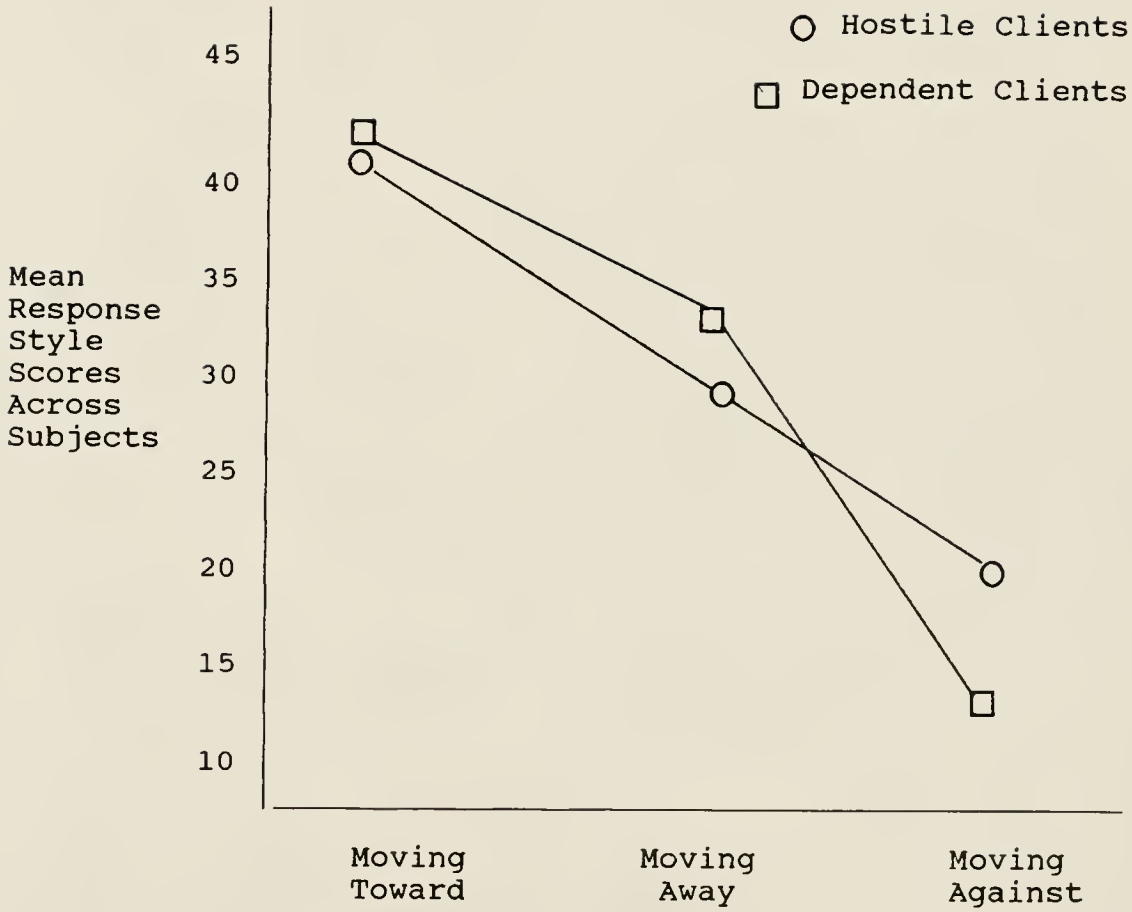


Figure 1. Interaction of Client Affect and Response Style

Table 5

Newman-Keuls Post Hoc Comparison of Means from Interaction of Variables, Response Style, and Client Affect

| Specific Means Comparison | Difference in Means | Critical Values .05 | .01 | p |
|---|---|---|---|---|
| MT Hostile vs MT Dependent | -.50 | 1.719 | 2.283 | NS |
| MAw Hostile vs MAw Dependent | -4.71 | 1.719 | 2.283 | <.01 |
| MAg Hostile vs MAg Dependent | 5.21 | 1.719 | 2.283 | <.01 |
| MT Hostile vs MAw Hostile | 11.01 | 2.065 | 2.599 | <.01 |
| MT Hostile vs MAg Hostile | 20.44 | 2.271 | 2.793 | <.01 |
| MAw Hostile vs MAg Hostile | 9.43 | 1.719 | 2.283 | <.01 |
| MT Dependent vs MAw Dependent | 6.80 | 2.065 | 2.599 | <.01 |
| MT Dependent vs MAg Dependent | 26.15 | 2.526 | 3.030 | <.01 |
| MAw Dependent vs MAg Dependent | 19.35 | 2.271 | 2.793 | <.01 |

MT = Moving Toward Response Style

MAw = Moving Away Response Style

MAg= Moving Against Response Style

Hostile = Hostile Client Affect

Dependent = Dependent Client Affect

While by far the greatest tendency of subjects was to respond empathically (moving toward) to both client affects, with sequentially decreasing propensities to reply in a directional changing (moving away) and counterantagonistic manner (moving against), there was a significantly

greater predisposition to respond with counteraggression to hostile, as opposed to dependent, clients. Similarly, the tendency to endorse directional changing responses (moving away) was significantly higher with dependent as compared to hostile clients. Gender of client or subject did not influence the response choices of the therapists.

Findings Related to Hypothesis II

Hypothesis II operationalized the interest in comparing the therapist's proclivity to responding empathically when he is acknowledging the possibility that he may be the target of the client's statement (involved therapist), as opposed to when he chooses to interpret the client's communication as referring to situations and relationships external to the session (generalized statement). This investigation was confined to a comparison of the weighted scores in the moving toward category in these subdivisions, which were crossed with client affect, client gender, and counselor gender. Inclusion of the target involvement variable necessitated a division of the data into two subsets, generalized responses, and replies opening up the implication of the interaction upon the client's reactions. Consequently, a 2 (target involvement) X 2 (client affect) X 2 (client gender) X 2 (counselor gender) multiple factorial design resulted. As it was important to look at the interaction of all levels of these variables on empathic response

tendencies, a MANOVA (Winer, 1971, pp. 322-340) was utilized (see Table 6). A significant three-way interaction occurred among the variables of target involvement, client sex, and sex of subject $F(1,40)=4.77$, $p<0.035$.

Table 6

Multivariate Analysis of Variance for Target Involvement, Client Affect, Client Sex, and Sex of Subject

| Variables | df | F | p |
|---|---|---|---|
| Involvement-Affect-Client Sex-Subject Sex | 1,40 | 0.33 | 0.568 |
| Involvement-Affect-Client Sex | 1,40 | 0.45 | 0.504 |
| Involvement-Affect-Subject Sex | 1,40 | 1.82 | 0.185 |
| Involvement-Client Sex-Subject Sex | 1,40 | 4.77 | 0.035 |
| Involvement-Client Sex | 1,40 | 2.33 | 0.135 |
| Involvement-Sex of Subject | 1,40 | 0.08 | 0.779 |
| Involvement-Affect | 1,40 | 0.48 | 0.492 |
| Involvement | 1,40 | 16.46 | 0.002 |

The therapists in general were more likely to respond in an empathic manner when they were not acknowledging their possible influence on their client's statements (see Figure 2). Post hoc comparisons of the group means via the Newman-Keuls procedure (Winer, 1971, pp. 191-195)

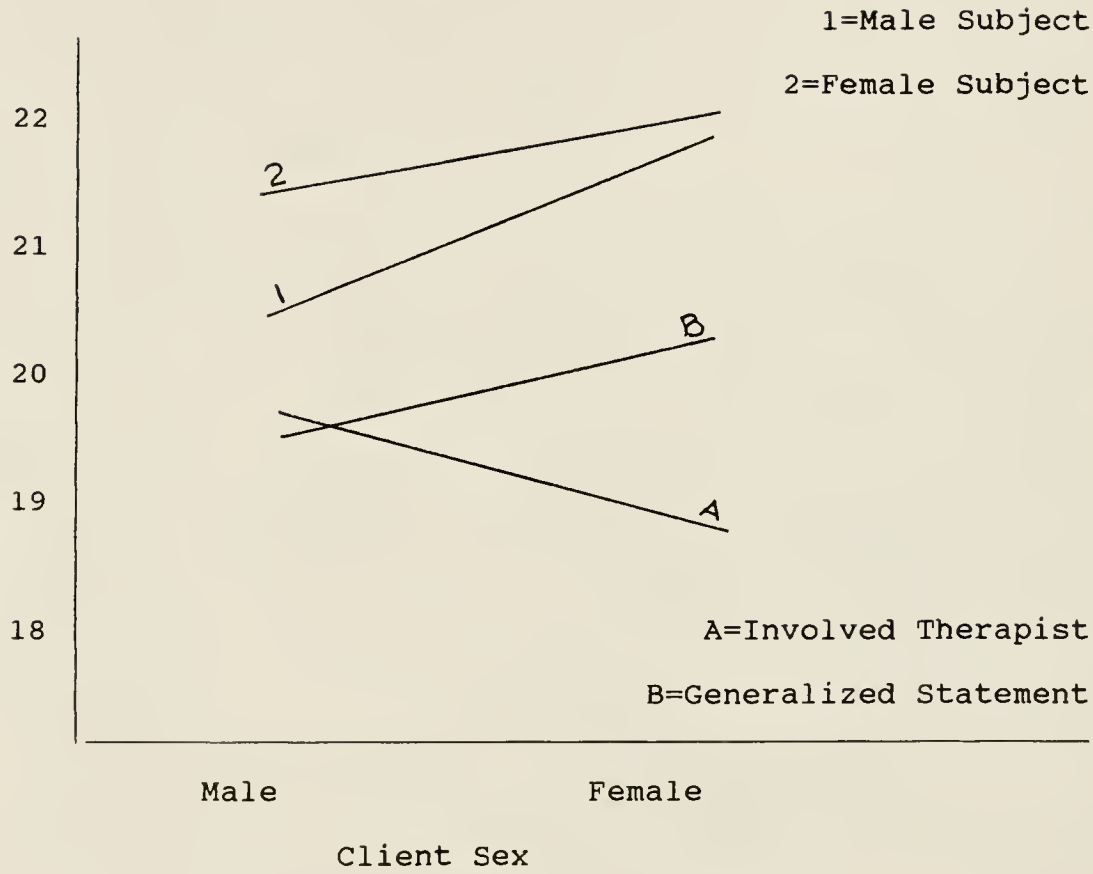


Figure 2. Interaction of Target Involvement, Client Sex, and Sex of Subject

highlighted the specific differences that accounted for the significant three-way interaction among the target involvement, client sex, and sex of subject variables (see Table 7). Specifically, it was found that male subjects endorsed empathic statements of a generalized nature significantly more often ($p<.05$) than empathic responses involving the therapeutic relationship with female clients.

Table 7

Newman-Keuls Post Hoc Comparison of Means for Interaction of Variables, Target Involvement, Client Sex, and Sex of Subject

| Specific Means Comparison | Difference in Means | Critical Values .05 | .01 | p |
|---|---|---|---|---|
| MA1 vs MA2 | .10 | 1.58 | 2.11 | NS |
| FA1 vs FA2 | -1.47 | 2.09 | 2.60 | NS |
| MA1 vs FA1 | .85 | 1.95 | 2.47 | NS |
| MA2 vs FA2 | -.72 | 1.86 | 2.36 | NS |
| MB1 vs MB2 | -.88 | 1.58 | 2.11 | NS |
| FB1 vs FB2 | -.04 | 1.58 | 2.11 | NS |
| MB1 vs FB1 | -1.20 | 1.95 | 2.47 | NS |
| MB2 vs FB2 | .36 | 1.86 | 2.36 | NS |
| MA1 vs MB1 | -.70 | 1.95 | 2.47 | NS |
| FA1 vs FB1 | -2.75 | 2.48 | 2.98 | <.05 |
| MA2 vs MB2 | -1.68 | 2.18 | 2.66 | NS |
| FA2 vs FB2 | -1.32 | 2.18 | 2.66 | NS |

M = Male client

F = Female client

A = Involved therapist empathic statement

B = Generalized empathic statement

1 = Male subject

2 = Female subject

This pattern of being significantly less likely to comment on the real or transferential aspect of the current therapeutic interaction in a cross gender pairing was not found in conjunction with female subjects.

When consideration of the generalized response alternative endorsements were excluded, leaving only rates of involvement to be compared, some trends were noted both across and within subject gender. Female therapists had a higher rate of comment on the current interaction in connection with female clients than male subjects did, but this difference did not reach statistical significance. This same comparison in conjunction with male clients showed very little difference in the tendency for subjects of either gender to endorse personally involving statements. Examination of the data within each subject gender revealed that while the involvement rate was higher within same sex pairings, these differences did not approach statistical significance.

## Findings Related to Hypothesis III

Prior to testing this hypothesis, statistics were performed to describe the relative and cumulative influence of the therapist gender, personality, and experience variables on the dependent measures. Multiple regression correlations were chosen, as this method provides

information about the relative predictive strength of the possible combination of independent factors on the criterion variable and permits use of the data in its continuous form without the need to impose an artificial dichotomy on the variables. Stepwise procedures were utilized to build the best predictive model, as there was not a complete apriori hierarchical arrangement of the variables intended. The resulting model depicts the variables in descending order of their contribution to the shared variance of the criterion variable. The absence of independent variables in the summary of analysis indicates that the factor did not reach the 0.15 level of significance set for entry into the model by the SAS program (Subroutine Stepwise Regression). Two sets of analysis were necessary due to the two different types of dependent measures, one data set involving the overall response styles, while the other centered on the response endorsements when the target involvement variable was included. Results will be presented for the former first and then the latter.

Separate multiple regressions were conducted for each of the three criterion response styles (moving toward, moving away, and moving against) in relation to hostile clients (see Table 8) and dependent clients (see Table 9).

Table 8

Summary of Multiple Regression Analysis of Independent Variables: Sex of Therapist, Hostility, Anxiety, Need for Approval, Emotional Empathy, Cognitive Empathy, and Experience on the Response Styles in Relation to the Hostile Clients

| Criterion Variable | Independent Variable | Number In | B Value | Partial R2 | Model R2 | F | p |
|---|---|---|---|---|---|---|---|
| Moving Toward | M-E Measure of Emotional Empathy | 1 | 0.2709 | 0.1427 | 0.1427 | 6.66 | 0.014 |
| | Hogan Empathy Scale | 2 | -0.8118 | 0.1249 | 0.2676 | 6.65 | 0.014 |
| | S-T Anxiety Inventory | 3 | -0.4946 | 0.1012 | 0.3689 | 6.09 | 0.018 |
| Moving Away | Sex | 1 | -6.4819 | 0.0871 | 0.0871 | 3.81 | 0.058 |
| | M-E Measure of Emotional Empathy | 2 | -0.1507 | 0.0528 | 0.1398 | 2.39 | 0.130 |
| Moving Against | Hogan Empathy Scale | 1 | 1.0715 | 0.1499 | 0.1499 | 7.05 | 0.011 |
| | Sex | 2 | 8.3723 | 0.0871 | 0.2371 | 4.45 | 0.041 |
| | Number of Hostile Clients* | 3 | -0.0659 | 0.0622 | 0.2993 | 3.37 | 0.074 |

*Previous experience with hostile clients.

Table 9

Summary of Multiple Regression Analysis of Independent Variables: Sex of Therapist, Hostility, Anxiety, Need for Approval, Emotional Empathy, Cognitive Empathy, and Experience on the Response Styles in Relation to the Dependent Clients

| Criterion Variable | Independent Variable | Number In | B Value | Partial R2 | Model R2 | F | p |
|---|---|---|---|---|---|---|---|
| Moving Toward | M-E Measure of Emotional Empathy | 1 | 0.1136 | 0.0683 | 0.0683 | 2.93 | 0.095 |
| Moving Away[a] | | | | | | | |
| Moving Against | Number of Dependent Clients* | 1 | -0.0599 | 0.0640 | 0.0640 | 2.73 | 0.106 |
| | M-E Measure of Emotional Empathy | 2 | -0.0808 | 0.0532 | 0.1171 | 2.35 | 0.133 |

*Previous experience with specific client types.

[a]No variables met the 0.15 significance level.

The multiple regression correlations yielded the following results with respect to the hostile clients: the empathy and anxiety variables combined to account for 37% of the variance in the moving toward scores; sex of therapist explained 9% of the variability in the moving away score; the cognitive empathy factor, together with the

sex of therapist variable, was responsible for 24% of the variance in the moving against response style.

The directional relationship of the significant factors on the criterion response styles used with hostile clients were as follows: emotional empathy was positively correlated with the moving toward response, while cognitive empathy and trait anxiety were both strongly and negatively correlated with this response type; both being male and scoring low on the emotional empathy measure were related to a higher level of endorsement of the moving away response; high scores on the cognitive empathy measure, being a female subject, and having less experience with hostile clients were all correlated with a tendency to select moving against responses. However, none of the considered variables were statistically significant in their contribution to explaining the variability in responding to the dependent clients.

Analysis of the influence of counselor gender, personality, and experience variables on the tendency for the therapist to respond empathically by involving the impact of the present interaction, or making a more generalized statement concerning the client's affect, necessitated four multiple regression correlations. A summary of the results of the analyses on the following four criterion variables appears in Table 10:

Table 10

Summary of Multiple Regression Analysis of Independent Variables: Sex of Therapist, Hostility, Anxiety, Need for Approval, Emotional Empathy, Cognitive Empathy, Experience on Empathic Responses of an Involved and More Generalized Nature

| Criterion Variable | Independent Variable | Number In | B Value | Partial R2 | Model R2 | F | p |
|---|---|---|---|---|---|---|---|
| HITMT[a] | Hogan Empathy Scale | 1 | -0.5140 | 0.1763 | 0.1763 | 8.56 | .006 |
| | M-E Measure of Emotional Empathy | 2 | 0.1543 | 0.1512 | 0.3274 | 8.77 | .005 |
| | S-T Anxiety Inventory | 3 | -0.2131 | 0.0532 | 0.3806 | 3.26 | .079 |
| HGSMT[b] | M-E Measure of Emotional Empathy | 1 | 0.1176 | 0.0661 | 0.0661 | 2.83 | .100 |
| | S-T Anxiety Inventory | 2 | -0.2895 | 0.0787 | 0.1448 | 3.59 | .066 |
| | Hogan Empathy Scale | 3 | -0.2892 | 0.0807 | 0.2255 | 3.96 | .054 |
| DITMT[c] | M-E Measure of Emotional Empathy | 1 | 0.0856 | 0.0780 | 0.0780 | 3.38 | .073 |
| DGSMT[d]* | | | | | | | |

[a]Involved therapist statement moving toward hostile clients.

[b]Generalized statement moving toward hostile clients.

[c]Involved therapist statement moving toward dependent clients.

[d]Generalized statement moving toward dependent clients.

*No variables met the 0.15 significance level.

involved therapist statement moving toward with hostile clients (HITMT); generalized statement moving toward with hostile clients (HGSMT); involved therapist statement moving toward with dependent clients (DITMT); generalized statement moving toward with dependent clients (DGSMT).

The cognitive and affective empathy variables combined to account for 33% of the variance in the involved therapist moving toward score for hostile clients, while the anxiety and empathy factors explained 23% of the variable in the general statement moving toward score for hostile clients. The pattern of scores on the personality variables was similar for both categories of empathic response toward hostile clients. These therapists tended to score low on the cognitive empathy and anxiety measures, while reporting higher levels of affective resonance with others. However, a much stronger negative correlation was found between cognitive empathy scores and therapists' endorsement of more involving responses to the hostile clients. None of the personality factors tested reliably accounted for a significant portion of the criterion variables in conjunction with dependent clients. Thus, in analyses of both sets of data, these factors contributed to predicting the subjects' response to hostile clients, but not to dependent clients.

Pearson product-moment correlation coefficients were computed for all independent variables (see Table 11),

Table 11

Pearson Product-Moment Correlation Coefficients between the Independent Variables

| | BDHI | STAI | M-C SDS | HES | M-E MEE | NOHC[a] | NODC[b] |
|---|---|---|---|---|---|---|---|
| BDHI | 1.0000* | | | | | | |
| | .0000** | | | | | | |
| STAI | .3380 | 1.0000 | | | | | |
| | .0286 | .0000 | | | | | |
| M-C SDS | -.4970 | -.2793 | 1.0000 | | | | |
| | .0008 | .0733 | .0000 | | | | |
| HES | -.1354 | -.2592 | -.3348 | 1.0000 | | | |
| | .3927 | .0974 | .0302 | .0000 | | | |
| M-E MEE | .3166 | .4481 | -.1709 | -.0318 | 1.0000 | | |
| | .0411 | .0029 | .2792 | .8413 | .0000 | | |
| NOHC[a] | .0932 | -.0872 | .2395 | -.0853 | -.0672 | 1.0000 | |
| | .5571 | .5830 | .1267 | .5913 | .6725 | .0000 | |
| NODC[b] | .1789 | -.1129 | .1207 | -.0850 | -.0624 | .9100 | 1.0000 |
| | .2570 | .4764 | .4463 | .5924 | .6948 | .0001 | .0000 |

*Correlation Coefficient

**Probability

[a]Previous treatment experience with hostile clients.

[b]Previous treatment experience with dependent clients.

thus establishing their degree of interdependence and aiding in a more complete understanding of the interaction of the factors. Six significant correlations were highlighted with this method: the hostility score (BDHI) showed a strong negative relationship to the need for approval measure (M-C SDS) ($r=-.49$, $p<.001$); the hostility score (BDHI) also demonstrated a positive relationship to both the anxiety score (STAI) ($r=.34$, $p<.03$) and the emotional empathy score (M-E MEE) ($r=.32$, $p<.05$); the anxiety measure (STAI) was similarly positively related to the emotional empathy measure (M-E MEE) ($r=.45$, $p<.01$); the need for approval measure (M-C SDS) was inversely related to the cognitive empathy measure (HES) ($r=-.34$, $p<.04$); and the amount of experience with hostile clients (NOHC) correlated positively and strongly with the amount of experience with dependent clients (NODC) ($r=.91$, $p=.0001$).

Hypothesis III postulated that the empathy variable would be a significant factor determining response choice. It was geared to seeing if therapists' self-reports of emotional and intellectual responsiveness in everyday situations is related to their reply tendencies in therapeutic sessions. To test this hypothesis an analysis of covariance was performed. This procedure equates groups on one or more variables before testing for the effect of the criterion measure. In this case it was used to adjust the weighted response style scores for initial differences

in levels of empathy among the subjects, and then tested the means to see if there was still a significant difference. A positive F statistic would indicate that there were still other factors that impacted on the response choice, as the influence of the empathy variable was being controlled.

A prerequisite for the use of analysis of covariance is that the covariate be related to performance on the means which are being compared. Perusal of the multiple regression analyses of the independent factors' influence on response endorsements for hostile (Table 8), dependent (Table 9), and across clients (Table 10) reveals that this prerequisite is met only for the data on hostile clients. Consequently, empathy covariate analyses were run solely for the hostile client data.

Sex of the hostile client and response style were crossed to produce six trials on which the empathy covariate was tested: weighted moving toward score with hostile male client (HMMT), weighted moving toward score with hostile female client (HFMT), weighted moving away score with hostile male client (HMMA), weighted moving away score with hostile female client (HFMA), weighted moving against score with hostile male client (HMMAG), and weighted moving against score with hostile female client (HFMAG). The means and standard deviations for these trials are listed in Table 12.

Table 12

Cell Means and Standard Deviations of Criterion Response Styles

| Response Trials | Sex of Subjects Male(N=20) | Female(N=22) |
|---|---|---|
| Hostile Male Client Moving Toward | 39.200* | 39.818 |
| | 6.53** | 6.53 |
| Hostile Female Client Moving Toward | 40.100 | 42.818 |
| | 5.86 | 4.22 |
| Hostile Male Client Moving Away | 31.400 | 29.091 |
| | 6.90 | 6.29 |
| Hostile Female Client Moving Away | 31.400 | 26.000 |
| | 7.63 | 7.93 |
| Hostile Male Client Moving Against | 19.400 | 21.091 |
| | 6.72 | 8.52 |
| Hostile Female Client Moving Against | 18.500 | 21.182 |
| | 6.80 | 7.70 |

*mean

**standard deviation

Due to the relative influence of the two empathy variables found in the multiple regression correlations and the Pearson product-moment correlation coefficients computed for the empathy variables and response criterion (see Table 13), the emotional empathy variable (M-E MEE)

Table 13

Pearson Product-Moment Correlation Coefficients between Empathy Variables and Endorsed Response Styles in Relation to Hostile Clients

| | Empathy Variables | |
|---|---|---|
| Response Style | M-E Measure of Emotional Empathy | Hogan Empathy Scale |
| Moving Toward | .3778* | -.3653 |
| | .0014** | .0174 |
| Moving Away | -.2842 | -.1014 |
| | .0682 | .5228 |
| Moving Against | -.0163 | .3872 |
| | .9184 | .0113 |
| Generalized Statement Moving Toward | .2571 | -.2043 |
| | .1002 | .1943 |
| Involved Therapist | .4020 | -.4120 |
| | .0083 | .0056 |

*correlation coefficient

**probability

was used as the covariate in the first four of these trials, and the cognitive empathy variable (HES) was run as the covariate in the two moving against response trials (see Table 14). This analysis yielded a significant F statistic $F(2,79)=76.18$, $p<.0001$. Even when the empathy variable is controlled for, there is still a significant

difference in the choice of response styles in conjunction with hostile clients. While empathy is an important variate, other factors also appear to have a potent influence on the therapists' endorsed response tendencies.

Table 14

Analysis of Covariance with Empathy as the Covariate and Response Style as the Criterion in Relation to Hostile Clients

| Source | Sum of Squares | df | Mean Squares | F | p |
|---|---|---|---|---|---|
| Response Style | 17121.93015 | 2 | 8560.96507 | 76.18 | .00001 |
| Residual | 551.49590 | 2 | 275.74795 | | |
| Empathy Covariate | 159.81997 | 1 | 159.81997 | | |
| Error | 8878.41640 | 79 | 112.38502 | | |

# CHAPTER V
# DISCUSSION

## Introduction

The purpose of the present investigation has been to shed some light on the factors that influence the therapist's response tendencies with hostile clients. Data were collected concerning replies to dependent patients and were used for comparison to help in uncovering the differential impact these variables had with the opposing client types. The criterion response style was divided into three categories: moving toward (empathic), moving away (directional changing), and moving against (counteraggressive), which was based on Horney's (1945) theory of interpersonal styles.

Past research (Bandura, Lipsher, & Miller, 1960; Gamsky & Farwell, 1966; Varble, 1968) has highlighted a difference in the tendency to respond empathically when the therapist's replies include himself and implications of the present interaction on the client's affect, as opposed to when he makes generalized comments referring to the impact of external relationships. The possibility of such countertransferential presence was addressed by including a target involvement variable in the moving toward responses. Thus, this criterion category could be

subdivided, and the endorsement of therapist-involved empathic responses was compared to that of the facilitative responses of a more general and less personally involving nature.

The relative individual and cumulative influence of a number of variables on response style endorsements were tested. The specified factors were of four types: client affect, a two level variable consisting of hostile and dependent clients; gender variables, including both client sex and sex of subject; therapist personality characteristics, comprising scores on measures of hostility, anxiety, need for approval, cognitive empathy, and emotional empathy; and experience variables, operationally and separately defined as the number of hostile and dependent clients treated. Discussion of the findings will be segmented into sections on each of these four factor categories. This will be followed by a summary of the implications and an examination of the limitations of the present study with suggestions for future research.

## Client Affect

Subjects in this investigation responded with a high degree of empathy to both hostile and dependent clients. However, there was more of a tendency to withdraw from dependent clients and a significantly greater reaction of counteraggression with the hostile clients. This general finding is a reconfirmation of Keren-Zvi's (1980) work, which similarly reported a relatively higher moving away

score with nonhostile patients and a trend, although not significant ($t=1.86$, $p<.07$), of counterhostile responses to hostile patients. Therapists' response ratings did reveal a tendency to protect themselves from the excessive nature of the client's affect in accord with the manner suggested in the literature. Specifically, these results support previous empirical findings that the therapist's tendency is to become more directive and controlling in response to client dependency (Bohn, 1967; Heller, Myers, & Kline, 1963) and to defensively react to antagonistic patients (Faries, 1958; Formento, 1980; Nadelson, 1977).

The same descending order of response endorsements existed for both hostile and dependent clients; moving toward was followed by moving away, with moving against coming in last. This positioning of the avoidant and antagonistic responses, along with the significant increase in aggressive replies to hostile clients on the whole, is in line with the thinking that the therapist is most apt to move away from hostile clients and attempt to diffuse the affect by becoming content-focused and directive (Hector et al., 1981), but he is also more likely to eventually react defensively with counter-aggression to antagonistic patients (Faries, 1958; Formento, 1980; Nadelson, 1977). This significant finding supports the results of Gamsky and Farwell (1967), Heller, Myers, and Kline (1963), and Mueller and Dilling (1968) that antagonstic client behavior leads to reciprocal

hostile responses from the therapist. Hostile demeanor appears to effect the counselor's perspective-taking ability; there is greater difficulty in reframing and reformulating interventions to be useful with an antagonistic client.

Even more striking than the somewhat expected tendencies toward counterproductive responses with hostile clients was the high level of empathic endorsements shown with these clients. Review of the above mentioned literature leads one to expect a bleaker picture. Yet this occurrence cannot be looked at as a simply aberrant statistic, as both the present study and Keren-Zvi's (1980) found a high level of moving toward responses that did not discriminate between the two client types. This is interesting given both the theoretical contentions and the previous empirical findings that there are significant difficulties in responding in a facilitative manner to hostile clients.

The relative differences in response style are expected, but the overall consistency of facilitative responding suggests that therapists can discriminate the more productive response when presented with the options. Thus, therapists on the whole did not solidify maladaptive styles, but were able to choose responses that altered expectations set by the client's interpersonal mode and allowed the possibility of a growth-producing interaction. The implications of this finding that high levels of

empathic responding were evident in the initial session is important as it has been shown that the amount of understanding communicated in the early phase of treatment is correlated with its success or failure (Strupp, 1980b; Winder et al., 1962).

Whether or not counselors could generate as high an empathic response rate as shown in this study given free rein with such difficult clients is questionable. This is particularly so when the elevated tendency to counteraggress when controlled options are presented is considered. If there is, as was postulated by Winnicott (1949) and Kernberg (1965), an objective countertransferential response that is roused by an antagonistic client, therapists seem more able to quell expression of such a reply and remain facilitative when structured alternatives are imposed upon their behavior. The studies that allowed therapists to generate their own responses (Gamsky & Farwell, 1966; Hector et al, 1981; Heller, Myers, & Kline, 1963; Mueller & Dilling, 1968) were the ones that reported avoidant and reciprocal hostile responses from therapists.

The empathic response tendencies, when viewed from the perspective of the target involvement variable, likewise did not significantly differ between the two client affects. The endorsement of generalized responses was higher than therapist involved empathic replies for both client types. This result is in accordance with the findings of Bandura, Lipsher, and Miller (1960) and Varble

(1968) that therapists were more likely to respond facilitatively to externally rather than personally directed antagonism. The present study's results can be interpreted as showing that clinicians are also less likely to explore with the client the possible interpersonal effects of the therapeutic interaction on his demeanor. The dependency literature was split on the target involvement variable, with Snyder (1963) finding a low explorative rate with therapist-directed as opposed to other-directed dependency, and Schuldt (1966) finding the reverse with his sample. The present study supports Snyder's (1963) contention, as there was a smaller tendency to invite the client to comment on dependency needs within the interaction than in his external relationships.

## Gender Effects

Measured independent characteristics of the subjects could not be differentiated on the basis of gender grouping. Neither the considered personality traits, hostility, anxiety, need for approval, cognitive and emotional empathy, nor the experience factor showed any consistently discriminating patterns between the sexes. This differs from Keren-Zvi's (1980) finding that female subjects were higher in trait anxiety and hostility using the same measurements that were used in the present study. While this may reflect idiosyncratic differences inherent to the samples, the subjects in the present study showed a wide range in their scores on these independent variables,

the distribution of which approximated the normal curve. Since these variables are presumed to also be normally distributed within the population, the sample was assumed to be representative.

The theoretical postulation that females on the whole are higher in affective empathic capacities (Freud 1925/1961; Hogan, 1969; Koffka, 1935; Parson & Bales, 1955) was not borne out by the data. It is possible that role indoctrination (Parsons & Bales, 1955) has been ameliorated and equated, or that the hypothesized more permeable boundaries of females (Bakan, 1966; Wyatt, 1967) have been solidified through professional training. Empirical reviews by Eisenberg and Lennon (1983), Hoffman (1977), and Hall (1978) suggest that throughout the life cycle females were emotionally more responsive and displayed a greater ability to intellectually perceive and accurately predict the emotional state of another. Some conflicting findings (Abramowitz, Abramowitz, & Weitz, 1976; Petro & Hansen, 1977; Sweeney & Cottle, 1976) led to questioning of whether this proposed female empathy advantage extended to the therapeutic community. The results of this investigation suggest that it does not, particularly as self-report measures such as were used in this study have in the past shown the largest gender discrepancy favoring females.

In addition to the absence of a significant difference between the sexes on the therapist personality

characteristics of empathy, there was no main effect of subject sex on the tendency toward facilitative responding. Without disputing the evidence that empathic capacities differ between the sexes in the general population, it is possible to explain these results by considering a preselection factor influencing the career choice of clinical work. Given the nature of the job, it may be that the more empathic from both sexes are called to the profession, or that once in training, environmental stimulation helps to maximize the development of such capacities. The latter is in accord with the finding by Abramowitz, Abramowitz, and Weitz (1976) that beginning trainees with thirty hours of supervision showed a female superiority in empathic responding, while Petro and Hansen (1977), using trained and practicing counselors, found no gender differences. One other important difference between these studies is that the former required the subjects to generate their own responses, while the latter, similar to the present investigation, allowed the therapists to choose from prepared replies. It is quite possible that inherent sex differences in empathic capacities may surface when asked to produce facilitative responses, but be masked in recognition tasks.

Results in this study showed that females were more likely to move against both sexes of hostile clients, and this tendency was also higher than in their male counterparts in conjunction with dependent clients.

However, their mean responses for moving away from both client sexes was lower than the male subjects for both affects. While counselor gender explained only a small amount of the variance, 9%, regarding selection of the counteraggressive and directional changing responses, it did appear that women therapists were more likely to respond directly to the clients of both sexes and affects than the male counselors.

There was no main effect of client sex on the tendency toward overall facilitative responding. This result is at odds with two studies (Petro & Hansen, 1977; Schwab, 1974) which found that practicing counselors of both sexes were more responsive to males than females across affect, and also with Gamsky and Farwell's (1966) finding that therapists were more facilitative with male hostility as opposed to female hostility. Given the paucity of studies in this area, it is difficult to make definitive statements; however, results of the present investigation suggest that counselors are not routinely more sensitively responsive to male hostility or dependency. The inconsistency of the findings may be related to the research questions asked. Client sex may appear to have significant impact when higher order interactions are not articulated or tested for, but recede in importance when more refined hypotheses consider not only gender composition of the dyad but also other

factors, such as target involvement variables, in their formulation.

The gender variables were significant when the target involvement variable was introduced into the moving toward response style. A significant three-way interaction revealed that male counselors were much less likely to endorse personally involving empathic statements with female clients than make externalizing general statements, while female therapists were much more apt to comment on the influence of the current interaction with their female clients than the male subjects. The level of involvement did not differ between the subject sexes in regard to male clients. Same sex pairs did not show a marked increase in personally involving empathic statements over opposite sex dyads. These results are interesting and not entirely anticipated, given the previously reported literature on sexual similarity. Theoretically, it is believed that the capacity for empathy is greater in same sex pairs (Allport, 1937; Dalton, 1983). Empirical findings supported this thinking in regards to undergraduate paraprofessional trainees (Olesker & Balter, 1972). However, this notion does not appear to extend to the tendency for the therapist to acknowledge the possibility of personal involvement with male clients. Both sexes showed a similar level of this propensity. The female therapists were more willing to open up the discussion of their influence on the client's presentation with male

clients than male subjects were willing to do with female clients. The tendency to gently and productively address the transference seems to be an independent factor in its own right and one on which this study provides tentative evidence that female subjects are more willing to attempt it across situations.

Unsupported was Langberg's (1976) conclusion that counselors approach therapist-directed hostility to a greater degree with opposite sex as opposed to same sex clients. The present study did not find gender factors to be significantly influential upon therapists' tendency to comment on the present interaction with hostile clients, but the discrepancy between the findings may be an artifact attributable to the extremely small sample size in Langberg's study (N=6). Furthermore, females were able to personally engage the clients and did not evidence extremely negative reactions to hostile males as found in Johnson's (1978) work, or become distressed beyond the range of their effectiveness with excessive dependency in female clients, as had been reported by Howard, Orlinsky, and Hill (1969). This study's findings were in accord with the report by Rappoport (1976) that female counselors were equally facilitative to hostile and nonhostile males. The inclusion of female clients in the present study indicates that this finding may not have been attributable to opposite sex pairing, nor may the lack of such findings for male therapists have been solely due to the unavaila-

bility of a cross sex pairing for male therapists in this previous study. Keren-Zvi (1980) found that while empathic response levels were high for both subject sexes, female therapists on the whole were more likely to offer a higher level of facilitation than their male counterparts. The results are also in accordance with the finding by Jones and Zoppel (1982) that female same sex pairs were particularly effective and that female therapists were on the whole seen as more empathic than the males. Looking at the cumulative impact of all these results, it may be justifiable to conclude that trained therapists of both sexes tend to be able to pick generalized empathic responses in an equivalent manner. While females are more likely to address transferential and countertransferential possibilities with clients of both sexes, males are more likely to discuss such matters only in a same sex dyad.

## Therapist Personality Characteristics

A very strong negative correlation existed between two of the therapist personality characteristics, hostility and need for approval ($r=-.50$, $p<.001$). The stronger the subject's reported dependency needs, the less he stated that he tended to respond with animosity and antagonism in everyday situations. This finding concurs with the formulation that hostility and dependency are opposing tendencies, with dependency and anger being respectively repressed (Horney, 1950). Similarly, this reported self-perception is in line with the finding of

Keren-Zvi (1980) that female therapists with a high need for approval were less aggressive and more facilitative with hostile patients. Thus, what is expected via theoretical formulation appears to be borne out in empirical investigation of the relationship between level of dependency need and initial handling of hostile expression in therapy.

While at first glance this may seem to contradict the notion that those who rely upon others' approval to maintain their self-esteen will move away from the disparaging client (Fromm-Reichmann, 1949), consideration of the duration of the hostile attack must be included in this formulation. Both the present study and Keren-Zvi's (1980), which found therapist dependency was not a handicap to handling hostile clients, dealt with the initial session. At the initiation of the relationship therapists may be able to withstand hostile attacks and remain facilitative, as they have yet to make an investment in the relationship or expect to impact on the client and can view this behavior as the client's base-line. However, it is quite possible that continued hostile barrages across sessions on a therapist with a high need for approval could easily become personalized by the clinician as both a rejection and an inability to affect change in the client, and thus erode his sense of security in the session with consequent limitations on his ability to remain facilitative. A cross-sectional study

focusing on the ability of therapists with varying levels of need for approval to endure their clients' attacks and remain empathic in response across sessions would be appropriate to substantiate this hypothesis.

A somewhat surprising positive correlation was found between the hostility measure and the emotional empathy scores in this study ($r=.32$, $p<.05$). Could it be that these therapists are more affectively responsive across a wide spectrum--that they are just more sensitive to emotions on the whole as opposed to a general damping down of affective sensitivity? This is quite possible given the finding by Peabody and Gelso (1982) that empathy and awareness of countertransferential feelings are positively related, while acting upon these emotions is negatively related to empathy. It is clear that empathy is an important mediating variable and that it is not necessarily as simple a formulation as had first been suggested, that those therapists who are high in hostility have difficulty in being facilitative to others.

Given the thinking regarding the occurrence of countertransferential blocks when unresolved personality issues are similar in counselor and clients (Berger, 1984; Cormier & Hackney, 1979; Mendelsohn, 1966), it was expected that the therapist's hostility level would directly affect his response choices with hostile clients, while his need for approval would significantly bear upon such endorsements with dependent clients. The first half

of this formulation was confirmed in Keren-Zvi's (1980) work; however, support for the direct nature of the negative impact of conflict similarity between patient and therapist was not found in the present investigation of either affect. Their own proclivities to hostile expression and the strength of their dependency needs did not influence the ability of the subjects in this investigation to see the defensive nature of the clients' communications. Thus, these results differ from Cutler's (1958) finding that therapeutic objectivity was interfered with by personally conflictual material.

Similarity in the therapeutic dyad on a predominant client trait neither significantly interfered with nor enhanced the clinician's ability to respond in an empathic manner. It is quite possible that therapists are able to begin the process of exploring conflicts with clients even if those issues are as yet unresolved within the counselor, and that this process becomes hampered when the collaborative effort reaches the point at which the therapist's own emotional development in that area was arrested. However, while this conceptualization could be indirectly supported if the research suggesting interference of personality similarity were based only on outcome studies, at first glance it does not account for the finding of a high termination rate following the initial session in dyads with excessive character structure similarity (Mendelsohn, 1966; Mendelsohn &

Geller, 1963, 1965, 1967). The key difference may be in terms of gradations of similarity in character structure. Clients in the present study were role played as rather extremes of the hostile and dependent type, respectively. While the subjects represented a broad spectrum in terms of hostility and need for approval, they did not reach the outer limits for presence of either trait. Possible range on the hostility measure was 0 - 66 and subjects scored between 7 and 45; likewise, the possible range on the need for approval measure was 0 - 33 and subjects scored between 3 and 25. Moderate personality similarity between counselor and client has been found to be conducive to a beneficial therapy experience (Carson & Heine, 1962; Mendelsohn & Geller, 1965). Subjects in the present study could be seen as moderately similar to the extreme personalities presented. It is conceivable that if there were a subset of subjects who more closely matched the marked presence of the depicted character pathology, and were observed over a series of sessions with these patients, then a greater degree of difficulty responding in an empathic manner may have been noted. This conjecture obviously cannot be tested with the available data, and researchers may have difficulty locating clinicians with such extremes in personality to test this hypothesis.

The findings of high premature termination rates by clients who have a similar character structure to their

therapist should also be interpreted within the context of treatment dropout on the whole. Studies (Garfield, 1980) have shown a generally high termination rate early on in therapy. For example, Fiester and Rudestam (1975) found 37% to 45% of patients dropped out of therapy after the first or second session. While personality similarity may be a factor in this occurrence, research (Garfield, 1980) has shown that more encompassing social class similarity and mutuality of therapy expectations are contributing influences to a client's decision to continue or abhort a therapeutic relationship. Additionally, a factor of unconscious sensitivity to the potentials and limitations of another may be a yet unaccounted for variable in the dynamics of early termination from a particular therapeutic situation.

Of the therapist trait variables considered in this study anxiety, cognitive empathy, and affective empathy appeared to be related to the therapist's choice in response style when confronted with hostile clients, but irrelevant to such decisions in conjunction with the dependent clients. A review of the results shows that the model consisting of affective empathy, cognitive empathy, and anxiety predicted 37% of the variance ($p<.02$) in overall moving toward scores with hostile clients, and 38% of the variance ($p<.08$) in the therapist-involved moving toward scores with the hostile clients. Elimination of the anxiety variable from the model dropped the explained

variance in the latter case to 33%, but the probability value was significantly strengthened ($p<.006$). As had been found in other studies (Bandura, 1956; Yulis & Kiesler, 1968), anxiety was negatively correlated with moving toward response choices both in the general and more personally involving categories. The results suggested that high scores on affective empathy were associated with higher levels of overall moving toward responses, as well as therapist-involved moving toward endorsements. On the other hand, cognitive empathy scores were negatively correlated with both moving toward response categories.

The two factor model of cognitive empathy and sex of therapist predicted 24% of the variance ($p<.05$) of the moving against response criterion with hostile clients. The sex of subject influence on this response category was discussed in the preceeding section on gender effects; the focus here will be on the understanding of the cognitive empathy variable. Scores on this variable are positively correlated with a tendency to endorse moving against responses with the hostile clients.

The results provide further evidence that the two types of empathy are tapping separate constructs and that the differences are truly more than semantic. Affective empathy refers to the emotional resonation with another; it appears that this type of feeling person is more likely to be able to take the client's perspective in formulating

facilitative responses and is inclined to address the implications of their interactions with the hostile client on the tone of therapy. The suggestion in the literature (Gladstein, 1983) that those high in affective empathy may be overwhelmed with the affect recognized in the client and be unable to communicate it, having to withdraw from the client, was not supported by this investigation. Cognitive empathy, while allowing an understanding of the client's position, seems to be a hindrance to effective responding with an antagonistic counselee. This was an unexpected finding, given the contention in the literature that cognitive empathy was more of an asset to therapy than affective empathy (Hogan & Henley, 1970). Cognitive empathy involves overly developed intellectualization abilities. High levels of cognitive empathy are linked to a more evolved sense of self (Carlozzi, Gaa, & Liberman, 1983; Hogan, 1969), but this may be at the expense of fostering relationship-developing abilities. The understanding of the client appears to occur at a distance, and thus may be interfering with the development of close human rapport and the communication of empathic interventions needed to promote changing expectations with difficult clients. The negative correlation between the need for approval measure (M-C SDS) and the cognitive empathy measure (HES) ($r=-.33$, $p<.04$) could be reflective of an independent orientation by those filling in this pattern, in that they neither see themselves as dependent

on others' estimations for their own sense of security, nor are they overly involved with others, and yet are interested in relating to the degree that the ability to conceptualize another's sentiments has been developed.

The positive correlation between the anxiety (STAI) and the hostility (BDHI) measures ($r=.34$, $p<.03$) corroborates the thinking of Horney (1937, 1945, 1950) and Sullivan (1953) that hostility and anxiety feed upon and reinforce each other, and reiterates this positive connection that was also observed by Keren-Zvi (1980). The anxiety literature (Money-Kyrle, 1956; Bandura, 1956) suggested that therapists high in this trait would tend to move away from clients. While this was not observed to occur in this study, anxiety did impact significantly and consistently on the endorsement of empathic responses. The more anxious therapists did not choose facilitative responses to hostile clients. This result was found both in relation to the more general and therapist-involving empathic statements. The influence of the anxiety factor could be explained by the postulation in the literature that the overall personal security level of the therapist impinges on his ability to be effective with hostile clients (Fromm-Reichmann, 1950). However, the impact of the anxiety variable appeared to be somewhat tempered by the influence of the empathy variables. It is possible that the anxiety variable seemed even more important in past studies because the empathy factors were excluded

from consideration. This statement is made in light of the positive and significant correlation between the affective empathy and anxiety measure used in this study ($r=.45$, $p<.003$). While the empathy variables are not the sole determining factors of response endorsement, as shown by the analysis of covariance, they are key variables in the endorsement of presented choices.

Therapist Experience Level

Even with the separate categories of experience level designed to reflect the amount of previous exposure to the specific client types under investigation, this variable did not have a significant influence on the response modes of the subjects. There was a trend for the experience factor to negatively correlate with the endorsement of moving against responses, but the amount of variability that was accounted for was small--for both hostile and dependent clients it was 6% and the probability did not reach significance levels, $p<.08$ and $p<.11$, respectively.

These results may reflect the effect of the limited range of experience in the sample of graduate students. However, even after the elimination of four extreme scores, there was some variability in expertise with the ranges for previously seen clients extending from 0 - 50 for both hostile and dependent clients. The high correlation of these two experience variables ($r=.91$, $p=.0001$) suggests that at this level of professional

development the breakdown of exposure for each client category was virtually meaningless.

The negligible impact of the experience factor suggests that at least within this somewhat narrowly defined range of expertise, novice counselors are no more thrown by their clients' hostility than by their dependency. The findings are consistent with the literature (Berry, 1970; Parsons & Parker, 1968; Strupp, 1980a) that suggests that greater exposure to the hostile client does not noticeably effect the types of interventions offered by the caregiver. This negligible impact of experience similarly extends to the target involvement variable. Past research has been equivocal, with one study (Gamsky & Farwell, 1966) showing that experience impacted positively on responses to therapist-directed hostility, while Varble (1968) found that experience helped with making facilitative statements about externally-directed animosity, but was irrelevant to the advancement of more personally involving responses. This study could not substantiate these impacts.

## Summary and Future Considerations

This investigation focused upon differential response tendencies toward hostile and dependent clients in an effort to understand the factors that contribute to maintaining a facilitative posture toward the respective types. Both the theoretical literature (Epstein, 1977; Faries, 1958; Formento, 1980; Groves, 1978; Nadelson,

1977) and previous empirical findings (Bohn, 1967; Gamsky & Farwell, 1967; Hector et al., 1981; Heller, Myers, & Kline, 1963; Mueller & Dilling, 1968) suggested that in general therapists withdraw from explorations of client dependency and respond with counteraggression to client hostility. Findings of both the current investigation and Keren-Zvi's (1980) work support the contention that while these differential response tendencies are present, there is an even greater trend toward choosing empathic responses from structured alternatives in an initial situation. The initial contacts with a client establish the nature and limits of the therapeutic relationship, molding expectations and creating an environment that is either receptive and offers understanding and support of exploration, or is aloof and somewhat sterile, if not perceived as openly rejected. In vivo studies of initial sessions with dependent and hostile clients in the past have shown a high level of counterproductive responses. This fosters the conclusion that the initial holding environment created for these clients is often barren, combatative, or at best inconsistently supportive. However, if therapists can recognize and endorse empathic responses toward these difficult clients, as was shown in this investigation, then there is hope that with specific focusing on the dynamics of the interaction and counter-transferential response patterns likely to occur with these client types, therapists can also learn to generate

facilitative responses. Future consideration should be given to a study whose protocol involves generating responses to hostile and dependent clients both prior to and following a seminar illuminating the above-mentioned dynamics and role playing appropriate interventions with these clients. Such a seminar would need to include specific exploration of how to comment on the impact of the interaction on the client's demeanor and means of discussing countertransferential reactions to therapist-directed aggression and dependency, as clinicians have been shown in both the present and past investigations (Bandura, Lipsher, & Miller, 1960; Synder, 1963; Varble, 1968) to refrain from exploring such issues with clients even when they are unquestionably operative. This is unfortunate, as these issues present an opportunity to learn what schemata the client is operating on and explore the effect of the client's behavior on others. If the results of such a study indicated that more consistently facilitative interventions were being generated past training, then some consideration should be given to instituting a similarly oriented seminar into the curriculum of training counselors.

The effect of gender noted in this investigation was not readily predictable from the literature. Results of this study suggested that the theoretically postulated female empathy advantage (Freud 1925/1961; Hogan, 1969; Koffka, 1935; Parson & Bales, 1955) did not extend to the

therapeutic community. Equivalence of empathy between the sexes was found both via self-report of empathic behavior and measured response endorsement to the clients presented. It would be interesting to see if these results held up in a similar study when therapists were given free rein to generate their own responses, especially in light of the greater tendency for the female counselors to move against clients. This may be indicative of there being a greater willingness on the part of female therapists to deal directly with a client, as opposed to avoiding strong or uncomfortable affect. This hypothesis seems plausible in light of the finding that females in this study were more willing to make personally involving statements and address transference issues in cross sex dyads than were male therapists. Gender pairing may be a more important factor for male counselors than for females. The notion of an empathy advantage in same sex dyads appeared to hold only for male counselors in the present study. It is difficult to reach even a tentative conclusion in this regard, given the variety of differing results compiled by previous investigations (Abramowitz, Abramowitz, & Weitz, 1976; Howard, Orlinsky, & Hill, 1969; Langberg, 1976; Olesker & Balter, 1972; Petro & Hansen, 1977; Rappoport, 1976; Schwab, 1974; Sweeney & Cottle, 1976). However, this tendency for male counselors to be more effected by the gender pairing could be further substantiated if these

results were replicated in an investigation involving the generation of responses.

Some of the therapist personality traits did not play as large a role in selection of responses as had been anticipated. Specifically, the idea that similarity in character structure, and thus consequentially, similarity in unresolved conflict, would hinder therapeutic responding, was not borne out by the data. It would be interesting to see if high personality and conflict similarity was more problematic further along in the course of therapy when the counselor has both a higher expectation of change and may have reached the limits of his ability to further explore the characterological component due to his own arrest in emotional development.

The level of therapist self-reported empathy appeared to be strongly correlated with the preferential endorsement of facilitative responses. Unexpectedly, it was affective empathy that was positively related to a high moving toward response choice, while cognitive empathy was negatively correlated with use of this response style and positively associated with endorsement of moving against alternatives. It may be that the ability to cognitively understand another's emotion does not readily transfer to the immediacy of gently and facilitatively intervening. Therapists who are more affectively responsive may be more able to provide involvement in addressing intense emotions, while those who are more comfortable with the

distance an intellectual understanding of another entails have some difficulty effectively operating on this knowledge in a close and highly emotional relationship. Given that this finding is at odds with the current theoretical assumptions of the role of affective and cognitive empathy (Hogan & Henley, 1970; Gladstein, 1983; Peabody and Gelso, 1982), this should be considered a tentative hypothesis awaiting replication.

Therapist experience with specific client types was not shown to markedly influence the response choice ratings. This may have been due in part to limits in the range of experience represented. However, if the report of subjects was accurate, they represented an experience spread from 0 - 50 with similarly afflicted clients, and yet the impact of that range of previous experience was negligible. It is possible that, as the literature has suggested (Berry, 1970; Parsons & Parker, 1968; Strupp, 1980b), experience does not lead to a generalized increase in facilitative responding to hostile clients. However, results of the present study have a limited generalizability to graduate students in various levels of counselor training. Before ascertaining that an objective countertransferential reaction and defensive respondling are not amenable to experience-based learning without accompanying personality restructuring in the therapist, a sample of practicing counselors with a more diverse range

of experience with these respective client types should be tested via the protocol.

The current investigation was an analogue study. This method was chosen in order to standardize the clinical situation to make comparisons across different groupings of therapists. However, results of an analogue study can not be presumed to bear a one-to-one correspondence with reality. One limitation on the generalizability of these findings inherent in the structure of this study was the abbreviated exposure to the client. The therapist was responding to 12-15 minute tapes and his responses may have differed had he been given the 50-minute exposure typical in client sessions. This study chose to sample therapists' responses to four different clients in this time-limited fashion; however, it is possible that different results might have been obtained that more closely approximated the actual course of clinical responsivity with a more prolonged client exposure.

In attempting to maintain methodological rigor, a compromise of the real fluidity of the therapeutic interaction was made and artificiality was introduced via a videotaped client and structured responses. The structured nature of the responses places constraints on the generalizability of the results. The fact that novice therapists endorse certain types of responses does not necessarily mean that in similar situations they would

generate these categories of responses with the same frequency. The next logical step in this line of research would be to alter the protocol and have therapists generate their own responses to the videotaped clients. It would be advantageous to have this next sample include both novice therapists and practicing counselors with varying levels of experience in order to tease out the affect of experience on response tendencies among a more diverse and meaningfully differentiated sample. If the results of such a study were able to replicate the factor structure found to be influential in the present investigation, then it may be time to move from analogue to in vivo designs.

Analogue studies are useful tools in refining research questions to the point where an understanding of the factors involved permits development of informed hypotheses to test out the conceptualization of the relationship among the variables in an in vivo situation. A premature move to experimentation in an actual clinical situation is inadvisable due to cost/benefit considerations. Given the manpower hours involved and the scarcity of available resources, one would not want to conduct a field experimentation as a preliminary investigation only to find that significant factors had been ignored and would necessitate yet another clinical trial to further hypothesis generation.

The current investigation was useful in generating information concerning the factors that contribute to empathic responding. An attempt to replicate this factor structure in a therapist-generated analogue study is the next logical step. If that proved successful, an in vivo study of therapists treating hostile and dependent clients should follow. It would then be time to further develop our understanding of how practicing therapists deal with hostile and dependent clients over the course of therapy, to see what impact the factors identified in this investigation have over time and to refine our knowledge about the longer term implications in our effectiveness with clients.

# APPENDICES

APPENDIX A
PILOT STUDY DATA

Overall Kendall Tau Correlation Coefficients for Response Agreement Among Raters

| | | Rater One | Rater Two | Rater Three |
|---|---|---|---|---|
| <u>Hostile Client Tape</u> (N=38) | | | | |
| Rater One | Moving Toward | - | .18 | .17 |
| | Moving Away | - | .13 | .31* |
| | Moving Against | - | -.25* | .10 |
| Rater Two | Moving Toward | | - | .08 |
| | Moving Away | | - | .10 |
| | Moving Against | | - | .02 |
| <u>Dependent Client Tape</u> (N=38) | | | | |
| Rater One | Moving Toward | - | .22 | .45** |
| | Moving Away | - | .20 | .50** |
| | Moving Against | - | .39* | -.08 |
| Rater Two | Moving Toward | | - | .20 |
| | Moving Away | | - | .14 |
| | Moving Against | | - | -.09 |

*$p<.05$ **$p<.01$

Appendix A--*continued*

Pearson Product Moment Correlation Coefficients for Response Agreement Between Rater One and the Experimenter

| | | Experimenter |
|---|---|---|
| *Hostile Client Tape* | | |
| Rater One | Moving Toward | .43** |
| | Moving Away | .56** |
| | Moving Against | .71** |
| *Dependent Client Tape* | | |
| Rater One | Moving Toward | .25 |
| | Moving Away | .22 |
| | Moving Against | .31 |

**$p<.01$

## APPENDIX B
## INFORMED CONSENT STATEMENT

The study in which I am participating investigates the relationship between therapist attributes, training experiences, and the therapist's counseling behaviors. I will complete a questionnaire describing my traits, attitudes, feelings, and behaviors. I will view four videotapes of clients in initial therapy sessions, and will respond to these clients as though I were the therapist in the interview situation.

I understand that the data will be kept under my code number, and will at no point be associated with my name. I understand that the researchers will look at the data in groups and not individually, and that anonymity and confidentiality will be maintained within the limits of the law.

I understand that this study may encourage me to focus on my personal beliefs and attributes as well as my counseling behaviors. This may facilitate my growth as an individual and a therapist. It is also possible that I may experience mild discomfort as a result of answering a self-evaluative questionnaire, and/or responding to the client videotapes.

Appendix B--<u>continued</u>

I understand that I may contact the individual listed below with any further questions regarding this research. I understand that no monetary compensation is involved for my participation. I understand that I am free to withdraw my consent and discontinue participation in this study at any time with no adverse consequences for myself.

I have read and I understand the procedure described above. I agree to participate in this procedure, and I have received a copy of this description.

| _____ | _____ | _____ |
|---|---|---|
| Subject | Date | Witness |

_____
Joyce Perrotta
Principal Investigator
378-2666

APPENDIX C
QUESTIONNAIRE

Subject No. _____

Listed below are statements concerning personal traits, attitudes, feelings, and behaviors. Read each item and circle the answer on the right which is most appropriate for you. Do not spend too much time on any one statement, and try to answer all the items.

1. My table manners at home are as good when I eat out in a restaurant.....T F

2. I don't really care whether people like me or dislike me.....T F

3. I commonly wonder what hidden reason another person may have for doing something nice for me.....T F

4. I am an important person.....T F

5. Another's laughter is not catching for me.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

6. I used to think that most people told the truth, but now I know otherwise.....T F

Appendix C--<u>continued</u>

| Almost | Sometimes | Often | Almost Always |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

7. I get in a state of tension or turmoil as I think over my recent concerns and interests.....1 2 3 4

8. I make decisions easily.....1 2 3 4

9. I take disappointments so keenly that I can't put them out of my mind.....1 2 3 4

10. I feel like a failure.....1 2 3 4

11. Sometimes without any reason or even when things are going wrong I feel excitedly happy, "on top of the world."....T F

12. When I disapprove of my friends' behavior I let them know it.....T F

13. I like to talk about sex.....T F

14. Some songs make me happy.....

| -4 | -3 | -2 | -1 | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|---|
| Very Strong Disagreement | | | | | | | | Very Strong Agreement |

15. The trouble with many people is that they don't take things seriously enough.....T F

16. Sometimes I rather enjoy going against the rules and doing things I'm not supposed to.....T F

17. I seldom feel that people are trying to anger or insult me.....T F

Appendix C--<u>continued</u>

18. I sometimes spread gossip about people I don't like.....T F

19. When people yell at me, I yell back.....T F

20. There have been occasions when I took advantage of someone.....T F

21. I have almost never felt the urge to tell someone off.....T F

22. When people are bossy, I take my time to show them.....T F

23. I prefer a shower to a bathtub.....T F

24. Even when my anger is aroused, I don't use "strong language.....T F

25. I would never think of letting someone else be punished for my wrongdoings.....T F

26. I am always careful about my manner of dress.....T F

27. If someone doesn't treat me right, I don't let it annoy me.....T F

28. I find it silly for people to cry out of happiness

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

29. On occasion I have had doubts about my ability to succeed in life.....T F

Appendix C--<u>continued</u>

30. Before voting I thoroughly investigage the qualifications of all the candidates.....T F

31. I'm always willing to admit it when I make a mistake.....T F

32. I sometimes have the feeling that others are laughing at me.....T F

33. People have often misunderstood my intentions when I was trying to put them right and be helpful.....T F

34. Becoming involved in books or movies is a little silly.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

35. I become nervous if others around me seem nervous..

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

36. When someone makes a rule I don't like I am tempted to break it.....T F

37. I sometimes think when people have a misfortune they only got what they deserved.....T F

38. I often find public displays of affection annoying

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

Appendix C--<u>continued</u>

39. I am always patient with others.....T F

40. I never play practical jokes.....T F

| Almost | Sometimes | Often | Almost Always |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

41. I am a steady person.....1 2 3 4

42. I feel inadequate.....1 2 3 4

43. I feel rested.....1 2 3 4

44. I worry too much over something that really doesn't matter.....1 2 3 4

45. I like to be with a crowd who play jokes on one another.....T F

46. I am irritated a great deal more than people are aware of.....T F

47. Although I don't show it, I am sometimes eaten up with jealousy.....T F

48. Only a fool would try to change our American way of life.....T F

49. I have a natural talent for influencing people.....T F

50. If I could get into a movie without paying and be sure I was not seen I would probably do it.....T F

51. I often find myself disagreeing with people.....T F

52. I always try to consider the other fellow's feelings before I do something.....T F

53. I could not put someone in his place, even if he needed it.....T F

Appendix C--<u>continued</u>

54. I have never intensely disliked anyone.....T F

55. On a few occasions, I have given up doing something because I thought too little of my ability.....T F

56. At times I feel I get a raw deal out of life.....T F

57. My motto is "Never trust strangers.".....T F

58. I never make a long trip without checking the safety of my car.....T F

59. I sometimes show my anger by banging on the table..T F

60. I am always courteous, even to people who are disagreeable.....T F

61. I sometimes carry a chip on my shoulder.....T F

62. When a man is with a woman he is usually thinking about things related to her sex.....T F

63. I liked "Alice in Wonderland" by Lewis Carroll.....T F

64. I don't seem to get what's coming to me.....T F

65. Clever, sarcastic people make me feel very uncomfortable.....T F

66. I like to gossip at times.....T F

67. I upsets me to see helpless old people.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

68. I am a good mixer.....T F

Appendix C--<u>continued</u>

69. People who continually pester you are asking for a punch in the nose.....T F

70. I am sometimes irritated by people who ask favors of me.....T F

71. I am afraid of deep water.....T F

72. Whoever insults me or my family is asking for a fight.....T F

73. I am very upset when I see an animal in pain.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

74. I tend to lose control when I am bringing bad news to people.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

75. I don't let a lot of unimportant things irritate me.....T F

76. I don't like to work on a problem unless there is the possibility of coming out with a clear-cut and unambiguous answer.....T F

77. My mother or father often made me obey even when I thought that it was unreasonable.....T F

78. I don't know any people that I downright hate.....T F

Appendix C--<u>continued</u>

79. Most foreigners I have met seemed cool and unemotional

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

80. I have never deliberately said something that hurt someone's feelings.....T F

81. When arguing I tend to raise my voice.....T F

82. I seldom strike back, even if someone hits me first.....T F

| Almost | Sometimes | Often | Almost Always |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

83. I am happy.....1 2 3 4

84. I lack self-confidence.....1 2 3 4

85. I am content.....1 2 3 4

86. Some unimportant thought runs through my mind and bothers me.....1 2 3 4

87. When someone is bossy I do opposite of what he/she wants.....T F

88. Sometimes I enjoy hurting persons I love.....T F

89. I like to talk before groups of people.....T F

90. I like to have a place for everything, and everything in its place.....T F

91. I know that people tend to talk about me behind my back.....T F

Appendix C--<u>continued</u>

92. I often make threats I don't really mean to carry out.....T F

93. I tend to get emotionally involved with a friend's problems.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

94. I demand that people respect my rights.....T F

95. If I have to resort to physical violence to defend my rights, I will.....T F

96. If somebody annoys me, I am apt to tell him what I think of him.....T F

97. Sometimes people bother me just by being around....T F

98. I easily become impatient with people.....T F

99. I often find that I can remain cool in spite of the excitement around me.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

101. When I really lose my temper, I am capable of slapping someone.....T F

102. I generally cover up my poor opinion of others.....T F

103. I enjoy the company of strong-willed people.....T F

104. I am not easily angered.....T F

Appendix C--<u>continued</u>

105. It's hard for me to just sit still and relax.....T F

106. I have at one time or another in my life tried
my hand at writing poetry.....T F

107. I never hesitate to go out of my way to help
someone in trouble.....T F

108. There have been occasions when I felt like
smashing things.....T F

109. I usually don't like to talk much unless I am
with people I know very well.....T F

110. I can't help getting into arguments when people
disagree with me.....T F

111. I tend to be on my guard with people who are
somewhat more friendly than I expected.....T F

112. I can't help being a little rude to people
I don't like.....T F

113. Little children sometimes cry for no apparent reason

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

114. Sometimes at the movies I am amused by the amount
of crying and sniffling around me.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

Appendix C--<u>continued</u>

115. At times I have really insisted on having

my own way.....T F

116. My feelings are not easily hurt.....T F

117. If somebody hits me first, I let him have it.....T F

118. There are a number of people who seem to

dislike me very much.....T F

119. I would like to be a journalist.....T F

120. There are a number of people who seem to be

jealous of me.....T F

121. I sometimes feel resentful when I don't get

my way.....T F

122. It is sometimes hard for me to go on with my

work if I am not encouraged.....T F

123. I don't get upset just because a friend is

acting upset.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

124. Before I do something I try to consider how

my friends will react to it.....T F

| Almost | Sometimes | Often | Almost Always |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

125. I feel that difficulties are piling up so

that I cannot overcome them.....1 2 3 4

Appendix C--<u>continued</u>

126. I have disturbing thoughs.....1 2 3 4

127. I feel secure.....1 2 3 4

128. I wish I could be as happy as others

seem to be.....1 2 3 4

129. It is the duty of a citizen to support his

country right or wrong.....T F

130. I have no enemies who really wish to harm me.....T F

131. When I am angry I sometimes sulk.....T F

132. The people around me have a great influence

on my moods.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

133. Seeing people cry upsets me.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

134. I really get involved with the feelings of the

characters in a novel.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

135. Once in a while I think of things too bad to

talk about.....T F

Appendix C--<u>continued</u>

136. No matter who I'm talking to, I'm always a good listener.....T F

137. I have seen some things so sad that I almost felt like crying.....T F

138. There have been times when I felt like rebelling against people in authority even though I knew they were right.....T F

139. I don't find it particularly difficult to get along with loud mouthed, obnoxious people.....T F

140. Lately, I have been kind of grouchy.....T F

141. I sometimes try to get even rather than forgive and forget.....T F

142. Often I can't understand why I have been so cross and grouchy.....T F

143. I have never been irked when people expressed ideas very different from my own.....T F

144. Disobedience to the government is never justified..T F

145. I have a pretty clear idea of what I would try to impart to my students if I were a teacher.....T F

146. I would certainly enjoy beating a crook at his own game.....T F

147. I sometimes pout when I don't get my own way.....T F

Appendix C--<u>continued</u>

148. People make too much of the feelings and

sensitivity of animals.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

149. I am usually rather short-tempered with people who

come around and bother me with foolish questions...T F

150. Most of the arguments or quarrels I get into

are over matters of principle.....T F

151. I always try to practice what I preach.....T F

152. When I get mad I say nasty things.....T F

153. It makes my blood boil to have someone make

fun of me.....T F

154. I frequently undertake more than I can accomplish..T F

155. What others think of me does not bother me.....T F

156. I would rather concede a point than get into

an argument about it.....T F

157. I am able to make decisions without being

influenced by people's feelings.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

158. I like poetry.....T F

Appendix C--<u>continued</u>

159. I lose my temper easily, but get over it quickly...T F

160. When a friend starts to talk about his problems, I try to steer the conversation to something else....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

161. Once in a while I cannot control my urge to harm others.....T F

162. I become more irritated than sympathetic when I see someone's tears.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

163. I never resent being asked to return a favor.....T F

164. If I let people see the way I feel, I'd be considered a hard person to get along with.....T F

165. I can remember "playing sick" to get out of something.....T F

166. I feel sure that there is only one true religion...T F

167. I like to watch people open presents.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

Appendix C--<u>continued</u>

168. My way of doing things is apt to be misunderstood by others.....T F

169. I like to keep people guessing what I'm going to do next.....T F

170. I cannot continue to feel OK if people around me are depressed.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

171. Lonely people are probably unfriendly.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

| Almost | Sometimes | Often | Almost Always |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

172. I am "calm, cool, and collected.".....1 2 3 4

173. I feel pleasant.....1 2 3 4

174. I feel satisfied with myself.....1 2 3 4

175. I feel nervous and restless.....1 2 3 4

176. When I am mad, I sometimes slam doors.....T F

177. I have never been made especially nervous over trouble that any members of my family have gotten into.....T F

Appendix C--<u>continued</u>

178. Unless somebody asks me in a nice way, I won't do what they want.....T F

179. A person needs to "show off" a little now and then.....T F

180. My parents were always strict and stern with me....T F

181. I think I would like to belong to a singing club...T F

182. I feel that it is certainly best to keep my mouth shut when I'm in trouble.....T F

183. There have been times when I was quite jealous of the good fortune of others.....T F

184. Other people always seem to get the breaks.....T F

185. When I look back on what's happened to me, I can't help feeling mildly resentful.....T F

186. I tend to be interested in several different hobbies rather than stick to one of them for a long time.....T F

187. I never get mad enough to throw things.....T F

188. Occasionally when I am mad at someone I will give him the "silent treatment".....T F

189. I think I am usually a leader in my group.....T F

190. I can remember being so angry that I picked up the nearest thing and broke it.....T F

Appendix C--<u>continued</u>

191. I am often so annoyed when someone tries to get ahead of me in line that I speak to him about it...T F

192. It makes me sad to see a lonely stranger in a group

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

193. I get into fights about as often as the next person.....T F

194. I used to like hopscotch.....T F

195. I have never felt that I was punished without cause.....T F

196. As a rule I have little difficulty in "putting myself into other people's shoes".....T F

197. It is hard for me to see how some things upset people so much.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

198. People today have forgotten how to feel properly ashamed of themselves.....T F

199. It bothers me when something unexpected interrupts my daily routine.....T F

200. Since the age of ten, I have never had a temper tantrum.....T F

Appendix C--<u>continued</u>

201. I would rather be a social worker than work in a job training center.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

202. I am annoyed by unhappy people who are just sorry for themselves.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

203. I usually take an active part in the entertainment at parties.....T F

204. Sometimes the words of a love son can move me deeply

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

205. I often feel like a powder keg ready to explode....T F

206. I become very involved when I watch a movie.....

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

207. Almost every week I see someone I dislike.....T F

Appendix C--<u>continued</u>

208. I get very angry when I see someone being ill-treated

```
----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

209. I am usually calm and not easily upset.....T F

210. I would like the job of a foreign correpondent for a newspaper.....T F

211. I have met problems so full of possibilities that I have been unable to make up my mind about them.....T F

212. I have known people who pushed me so far that we came to blows.....T F

213. I must admit I often try to get my own way regardless of what others may want.....T F

214. I am able to remain calm even though those around me worry.....

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----/-----/----/----/----/----/----/----/----/-----
   -4    -3   -2   -1    0    1    2    3    4
 Very Strong                                Very Strong
 Disagreement                                Agreement
```

215. I can remember "playing sick" to get out of something.....T F

216. I can think of no good reason for ever hitting anyone.....T F

## APPENDIX D
## TRANSCRIPTS OF VIDEOTAPED ROLE PLAYS

### Dependent Female--Kelly

th: Can you give me some idea why you're here?

cl: Well...I'm having some trouble with my roommates. Well, actually it's not just my roommates... it's...it's well, it's kind of hard to say...uhm just in the relationships in my life, I can't really seem to maintain them and I guess the reason why I came in is that, I mean specifically right now my roommates and I are...just aren't getting along that well, just not getting along, it's like they're cutting me off.

Response #1

cl: They're excluding me from everything, and you know I guess I feel silly, but I don't know what's wrong with me...this has happened before, it's happened before... yeah, we'll start off and we'll be, we'll get along great and I'll, we'll talk on the phone all the time and we'll go places and you know I'll think we'll be getting along really good and having so much fun and you know...

th: They lose interest in you, or something?

cl: Yeah...yeah, something like that. I don't know what

Appendix D--<u>continued</u>

to do because I'm really, it's starting to make me really unhappy.

th: I can tell you're really sad.

cl: I've been getting into these massive depressions...and I'll do anything, I'll do just anything just to get helped, to be able to change this.

<u>Response #2</u>

cl: uhm...well I'm, I'm not real outgoing, I've always been a little shy...but you know when I get to know people, I mean it takes me a little while, I'm not the kind of person who will walk up to people I don't know and introduce myself. Well, when I'm in a group, when I'm in big groups, I'm not, I'm not really very comfortable in large groups. I'd rather be like, you know on a one-to-one situation with someone. In groups I, you know, there are some people, they always get along with everybody, who are very outgoing...but I don't really feel very comfortable when I'm with a whole lot of people. I feel kind of insecure.

th: You really get sort of quiet and try not to offend people or...

cl: Right.

th: Not to be too showy maybe...

cl: Yeah, I just don't feel comfortable being that way.

Appendix D--<u>continued</u>

But when I'm with a person one-on-one, you know, I'm not really, I mean, I'm not shy, I can talk to people and I open up to them, I open up to people a lot.

<u>Response #3</u>

cl: I'm, I'm an open person when I'm with just one other person that I feel I can trust, somebody that I think is my friend, not that I just spill my guts to just some person I just meet, except to you, I guess.

<u>Response #4</u>

cl: I reached the point where I just really need to know what to do, how I can change, how I can change, how I can change.

th: It's not your usual style?

cl: No...no.

th: You kind of define yourself as sort of a nice, a sweet person, is that it?

cl: Yeah, yeah. I...I'm shy, I mean I think I'm shy, but I get along with people. I means I always think that when I meet them that people like me and I'm really eager to give...and to open myself up to them...and share my problems and things. Because I know a lot of people that can't talk about their problems and things and I can do that with people that I trust, I can and I do, I open up a lot to them.

Appendix D--continued

Response #5

cl: Well that's the problem, after I open up and I talk about all the things inside that are bothering me and just all my feelings about things, then they seem to withdraw and fade out. Like I'll call them up and want to come over and see them and I can tell they're making up excuses and things.

Response #6

cl: It's like I'm getting in the way, and that's what I don't understand, because I'd do anything, I'd do anything to please my friends, I mean, my friends are that important to me that I would just do anything for them. You know, so a lot of times I'll just come over and bring them a surprise, I like to just drop in on people like that...you know and I think it's really going to make them happy...and I'll call just to say hi and to ask how they're doing...but it's like they don't want me to do those things for them, they don't want me to do favors for them. I don't know, it's like they're too busy for me...I just never thought that by, you know, wanting to please your friends that that would turn them away.

Response #7

cl: I don't really like to be alone very much, I don't.

Appendix D--<u>continued</u>

th: You mean you get sort of down when you're alone.

cl: Yeah, I told you I've been really depressed, because since all my friends have gone their way I've been by myself and I get really depressed.

th: That must irritate you a little when they do that.

cl: Well, I...I mean I don't get mad at them because they have to do what they think is right, you know, they have to, I can't really get mad at them for not wanting to be with me...It's not their fault.

<u>Response #8</u>

cl: Dates and boyfriends that I had never lasted very long. You know, I just thought they didn't think I was attractive or something.

th: Physically attractive?

cl: Yeah...maybe, I don't know.

th: Maybe what, you didn't finish?

cl: Well, maybe I just wasn't fun enough...

th: Maybe you weren't a good time?

cl: Yeah...maybe they just didn't have fun with me...and you know...I try to be fun...I don't really feel like I'm having fun inside.

th: What's going on inside? That's a hard question.

cl: Maybe...maybe...I feel like I'm always working at everything, when I'm around people I don't feel relaxed. I don't feel relaxed. I'm uptight.

Appendix D--continued

Response #9

cl: What do you mean devilish side?

th: Well, you know, that would be a little like Halloween. On Halloween your devilish side might come out, the one that does the tricks and things.

cl: I don't do things like that. No, I don't, I like to be more honest with people. Devilish to me is like...a little kid doing things they're not supposed to on purpose.

th: Yeah, right, I think you got the picture.

cl: Well I...don't, I just don't do things like that.

th: You don't allow that sort of stuff?

cl: No, my parents were pretty strict bringing us up.

th: Yeah, I can tell that.

cl: But we get along really well, you know, I've always, we've always gotten along really well. We never had any conflicts, big things that I ever remember.

Response #10

Hostile Female--Kim

cl: Why do you think I'm here?

th: I don't really have any idea.

cl: Well, I don't think I'm edgy. I came in to decide if what I thought about my boyfriend is true, and I

Appendix D--continued

thought that you being the therapist that you could assure me on that.

Response #1

cl: Well...he seems to be getting kind of distant lately, he doesn't call me. We were supposed to go out to eat several times and he never called me. Now I see that as being very childish on his part...I'm here, he can call me and he doesn't.

th: Makes you mad as hell.

cl: Well, sure...Yeah I get pissed about it...but you know he's the one who's missing out on dinner. I mean I go anyway, I don't care if he goes with me or not. We make the date, he doesn't call, so I'm going to go to dinner. So, I see him as being very childish about this.

Response #2

cl: We used to get along pretty good. You know, I mean we got along all right. I would go out with him or he would go out wherever I wanted to go, but lately he's just not very considerate of my feelings you know, and I don't appreciate that. I mean, I'm always home and he can call me, and he doesn't. I'm not waiting for him. I means I'm not going to wait for him. I'm going to go out whether he's going to call me or not...but I don't have to wait for him.

Appendix D--<u>continued</u>

th: It just sounds like you're worried, you're home waiting for the call.

cl: No--I'm not waiting for the call. I just said I'm home, like if I go home to get a shower or something and I'm going to go out. I mean he can call me, he pretty much knows when I'm home, and he doesn't so, so I go out...but...he seems to think something is wrong with me, and I don't see it that way. I've talked to my friends, and they all agree with me, he's the one that's being very childish...I mean, I don't have to answer for my actions...you know, I'm not in the wrong.

<u>Response #3</u>

cl: What I want to know is, is he or isn't he immature. I mean...I think he's immature, and I'm just here to find out if he is or not. Somebody who does something like that, that's not very adult like. I think he's got the problem. I think he should come see somebody, but you know I can't make him go see somebody. I don't think that I've changed. I know I haven't changed...he's the one. All of a sudden he's going out with his friends, and uhm, I mean, that's ridiculous. They're going to fraternity parties and stuff like that, and getting drunk, and that's stupid. I just think he gets drunk, and by then he's too blitzed to figure out what he's

Appendix D--continued

supposed to do. I mean, it's his problem. Okay, I don't take anything personal from him.

Response #4

cl: Well it pisses me off, but like I said I have other things to do. I can't wait for somebody, I'm not going to. My girlfriends have said the same thing, why should we...I'm not upset, it doesn't bother me, he's just being childish. He's not indifferent, he's just not thinking properly.

th: So it doesn't feel that personal to you, it feels more.

cl: No, it's not personal. I think I can handle it, I'm adult enough...but, you know I'm getting kind of tired...I don't know...

Response #5

cl: No he's pretty much always been this way. I mean, I thought I could bring him out of it, you know, but I guess that it's not helped that much.... He doesn't treat me badly, he doesn't treat me indifferently either, he does pay quite a bit of attention to me when he's acting properly...but...

th: So kind of on his terms he'll relate to you pretty well?

cl: No, I don't think it's his terms, I guess I think it depends on his state of mind.

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th: Yeah, that's what I meant.

cl: Well if he's drunk is what I'm talking about, then he's not even thinking about himself, so if he's not thinking about himself then how can he think about somebody else.... He doesn't bother me, it's just being stupid that bothers me. I don't want anybody around me that's going to act stupid.... I do deserve better, don't you think?

<u>Response #6</u>

th: Sounds like you need a relationship that you get more out of.

cl: I don't know, he's got money, he's got money, and when he takes me out he pays for things. I'm not complaining too much, I just want him to grow up you know.... Actually, I'm not pissed at him, I just don't like the questions you're asking me.... Like I said, I don't like the questions you're asking me, so...you know I though you'd question me...I didn't even know you'd question me.

th: You thought I'd more question him.

cl: Yeah, I mean that's what we're here for right. I mean I want to find out about him. I guess he should be the one that should be in here, not me. You know he's got to face up to his life sometime, don't you think?

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Response #7

cl: But if he doesn't call, hey he missed dinner, that's his problem. I'm going out, so why should I get pissed. Sure, when we're together we have a good time. I'm not worried about that...he doesn't stand me up. Well, I guess he just can't get a hold of me. I don't see that as being stood up. He's never stood me up. No, he doesn't forget to call, like I said either he gets drunk or he's busy. Nobody stands me up because I've always got plans.

Response #8

th: You don't like these questions at all do you?

cl: No...I don't know, does anybody ever tell you that you ask very personal questions?

th: Yeah, all the time.

cl: Well, I mean, I just don't like that manner in which you ask them.

Response #9

cl: You know I've given a lot to this relationship.

th: It really sounds like it.

cl: I have, so that's what I'm saying, he's got the problem, I don't. You know you can only give so much, right...I'm not hurt...I mean I could find another boyfriend in no time. As a matter of act, he gets jealous of me.

Appendix D--continued

th: I believe you could find another boyfriend.

cl: Yeah, I could...I mean, I've got several friends...I consider myself, what I do top priority. I mean I'm not down on anybody's list...I'm out for me, everybody is, don't you think? You've got to take care of yourself, number one, first, right?

Response #10

Dependent Male--Steve

cl: I'm not quite sure, we have a good time you know, we go out and I try to be very nice, I try to be what she wants and uhm, lately she's been pulling away and I'm not quite sure why exactly. And I go to her and maybe I think that I'm, I don't know, not holding her enough or talking to her, so I do, and even when I do that it feels like she pulls away.... Yeah, I like her very much, maybe love, I don't know. We've been going out for about a year now and she's very special...I like being with her and I don't understand why at times she pulls away...Ah it's (sigh).

Response #1

cl: Well lately, lately I think that's what it's been, because I feel she's pulling away from me and I don't want that to happen.

th: So you are working harder.

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cl: Yeah, I think so...I, I like being by her and I don't want her to leave...she says that sometimes I don't give her enough room, and so I give her room and then I feel bad about being away from her, you know, I feel like maybe that's really why she wants to leave.

<u>Response #2</u>

th: Does she try with you, I mean does she do things for you?

cl: Yeah, she does...although lately (sigh) it hasn't been the greatest. She used to...I don't know. I like to have a good time with her. Maybe I don't show her enough, because I do, I like being with her very much..and, uhm, that's why I'm here too. I hope you can help me with this, I don't, uh, she's a wonderful lady.

<u>Response #3</u>

cl: Again, I don't want to lose. Usually if she wants me to do something, I say "hey, OK." And, uhm, you know, if we're around her friends I try to be very nice and anything that I can do to make things OK and to have a good time. Uhm...but...

th: But you do expect things from her, don't you?

cl: Well, I don't know if expect is the right word, but I'd like her to be with me...I don't know, if expect, is that what that is, well then I guess.

Appendix D--continued

Response #4

cl: I think its very important for a relationship to be, to be nice and to be outgoing and to get along.

th: Does that mean, though, if you don't try you're not nice....What does trying so hard mean?

cl: Well...I'm...I just don't want to lose her...I, I realize that something is wrong, that's why I'm here, hope that, that you can...I think you already have, that you've done some good things already....

Response #5

cl: I know that when I'm with people, I like to have a good time and I like that they can feel comfortable with me...and I really don't like...people, you know, if they don't like you, then they'll just leave...It's just a bad situation and I don't want to have that, I think it's very good to be nice.

th: You must not be nice all the way through, are there little sides of you that aren't so nice?

cl: Yeah, there's some, there's a few times, but I keep them to myself, why should you have to get out your frustrations on other people. Sure there are times, there are times.

th: Does your girlfriend know that side of you at all?

cl: No, I try not to let her see that side...You know, why should she have to see that side of me, that I really

Appendix D--<u>continued</u>

don't want to show her. Again it's something I have a problem with and I can, you know, I can get rid of it my own way.

th: How do you do that, how do you get rid of that?

cl: I just go off someplace and take walks and things, you know, just things like that...uhm, but I really don't want her to see that part, I want to make her happy.

<u>Response #6</u>

cl: Well, I don't know if she'd find it intriguing, to tell you the truth, it's not <u>really</u> a side I like to show other people, I guess...I don't know, do you think it might be a good idea to do...Yeah, maybe, yeah, but again I, I, I don't like to tell somebody else what to do, I don't like to say you do this or you do that...I don't know, I'm confused.

<u>Response #7</u>

cl: I usually can tell what to do depending on how she feels.

th: You can read her pretty well.

cl: Yeah, I read her pretty well and I try, try again, well I mean, I try to make things so they'll work out and, uhm, and I really don't think it's such a good idea not to, I don't know, I try, I think it's a good thing to do, but she doesn't feel that way.

th: What if she doesn't?

Appendix D--<u>continued</u>

cl: I'll change, I'll change and see what she wants...You know, I don't know if that's what she wants but I don't want to lose her. She's very special. She takes care of a lot of needs I have.

<u>Response #8</u>

cl: Well, I hope she would say that I treat her very well, and that she used to have a very good time and that she can relax and be comfortable around me, that I'll do anything for her, she knows that.

th: Do you fight with her?

cl: Uhm...no...not really, you know we talk about things...uhm but no, because in the long run I guess I know she's right (sigh).

th: How does it work out when she's not right?

cl: Uhm...she's...she's usually right, I mean...I don't, you know I think I have the problem and I...you know that's one of the reasons I'm here...I just want to make her happy...uhm...

<u>Response #9</u>

cl: Yeah, that's what she says.

th: That you're boring?

cl: Yeah, she says that...and boy that really makes me feel bad, like wow.

th: Not a very romantic word.

cl: Uhm...no...no...no.

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th: It made you feel more self-doubting.

cl: Yeah, yeah it did...I don't think I'm boring. I like to have a good time, I like to go dancing and whatever.... Well yeah, I want her to have a good time, I like makin' her happy, I like that. I uh...I like when she laughs and smiles and I feel real good about that. I mean I want her to know that I have a good time and that I want to make her happy, that's very important to me.

th: What if she wanted to make you happy?

cl: Uhm...I think that's OK. I mean I know that she would...I would see what she was doing...I would understand what she was trying to do and I would make her feel happy.

Response #10

Hostile Male-Manny

cl: I'm here because I feel there's some...most of the people I encounter, they have a hard time relating to someone like me and uhm...I'd kind of like to find out why that is.

th: What seems to happen?

cl: I uh.... People seem to be intimidated by me, they seem to be...they develop inferiority complexes about me or something.

Appendix D--<u>continued</u>

<u>Response #1</u>

cl: Most of me likes that in a way, I don't like to intimidate people but you know it's kind of rewarding to find, to see yourself so far above someone.

th: Yeah, it gives you a sense of power.

cl: But you know I could relate to that I could still be myself like that, others have a hard time!

th: So what do they do, kind of withdraw from you or leave you alone?

cl: Yeah, uh hum, that's it, pretty much. It's a shame, I would really like to spend more time with certain people...but when you withdraw...I can't say, uh, you know, it's kind of hard for me to deal with face on with them, what am I supposed to say, you're only withdrawing from me because you're so much more...I'm so much more intelligent than you or, uh, when we have a conversation I can only use four letter words with you otherwise you won't understand me.

<u>Response #2</u>

cl: I'm very content with myself, so I can be by myself and be very happy--sometimes I'm by myself more than most people do...still there are occasions when you might meet someone where at least on your side you get good vibrations from them...and then suddenly it turns into not competition, but an unchallenged competition where

Appendix D--<u>continued</u>

you end up winning and they end up withdrawing from you.

<u>Response #3</u>

cl: I can't remember the last time I really ever lost...you know.... Maybe I don't put myself in situations where I know I'll lose, but whatever the reason is...I don't, I don't, I never think of anything as being over my head.

<u>Response #4</u>

cl: I expect a lot of myself.

th: Does that mean you get down on yourself some?

cl: No...I mean no that if you don't, if your confident enough you're not going to lose at things you'll have, you'll meet things with a certain amount of success, why fear? I don't have to be completely successful, most of the time I am, but I don't have to be.... Some success is more than most people can ask for anyway.

th: Some is.... How do you explain that, is it kind of quick or intellectual or you know, how does success come to you?

cl: I don't know, Divine Providence, I guess. Some of us are gifted, we recognize it, but others...people recognize it too and since they're not, they go into a shell. I guess what I'm really here for is to try to somehow figure them, the outside world out. Sometimes I just try to lower my standards or get at another

Appendix D--continued

person's level. Jeez, that lasts about five minutes, then I go crazy, I gotta go, I can't do it. So I figure somehow maybe they can get up to my level, but with some people that's impossible. And then uhm...there must be a half-way point, I guess, I could bear that...there must be some...I don't know.

Response #5

cl: That I'm inviting them to admire me...

th: Oh yeah, isn't that what you're saying...that people notice and attend to and are intimidated by your superiority, I assume you communicate that to them.

cl: It sounds to me like you're calling me an egotist.

Response #6

cl: A good amount of self-confidence, you can't knock anybody for that

th: Yeah, that's what I thought.

cl: I don't expect anything of anybody else, I don't demand anything.... Well, I guess we do have our expectations.

Response #7

cl: I don't consider that a vulnerability, I'm not dissatisfied with myself, if anything I'm dissatisfied with others. Maybe that's a weakness I do have, that I don't understand, sometimes, others...you know, maybe that's an area I need to be educated in more.

Appendix D--<u>continued</u>

<u>Response #8</u>

th: I thought you were really kind of disappointed in their reaction to you.

cl: Yes.

th: You thought they would respond to you more personally, stay more involved with you?

cl: Yes, but it's out of my control...I mean it's nothing I do, or I do, you know....

th: It's probably something you do and something they do, those things are usually, there's some mutuality in them.

cl: Not in this case though!!!!...I don't feel responsible, you think I'm responsible? Do I seem intimidating?

<u>Response #9</u>

cl: I don't, I don't think I intimidate people, if I do it's not conscious...It's not something I seek to do, just the opposite problem.

cl: I have friends, I'm not involved with any special person in particular. I get bored real easy, I guess...I get bored with someone after we go see five movies together and you each come out feeling different and all they can discuss is how pretty John Travolta was and...that kind of stuff. Some people have really narrow minds, very weak intellectual capacities...just the giddiness that many girls express, the jealousy

Appendix D--<u>continued</u>

that many guys.... Ah, jealousy is a big problem, guys are really jealous of me...I don't understand it, it's kind of good, but it can be a problem.... Things like that can bore me to death, these trivial emotions some people display for no reason.

<u>Response #10</u>

APPENDIX E
RESPONSE ALTERNATIVES

Subject No._____

Dependent Female-Kelly

Response 1. A. It sounds like their treatment of you has been rather painful for you. (MTGS)[a1]

B. How have you managed to alienate them so completely? (MAG)[b]

C. How do they cut you off? (MAW)[c]

2. A. You really expect a lot from me. (MAG)

B. How does your behavior change when you're depressed? (MAW)

C. Sounds like you're feeling real desperate. (MTGS)

3. A. So you really control things! You hold out on others until you can get them alone and have their full and undivided attention. (MAG)

B. It sounds like you're sensitive to the risk involved in opening up, are you feeling cautious about opening up to me? (MTIT)[d]

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[1]Parenthetical material added:
[a]MTGS = Moving Toward Generalized Statement
[b]MAG = Moving Against
[c]MAW = Moving Away
[d]MTIT = Moving Toward Involved Therapist

Appendix E--continued

C. What kinds of people are you most comfortable with? (MAW)

4. A. How do you decide who can be trusted with your inner feelings? (MAW)

B. I guess you're wondering just how trustworthy I am too. (MTIT)

C. You expect me to be flattered by this admission! (MAG)

5. A. How did your family express anger to one another? (MAW)

B. Isn't it boring to be so nice all the time! (MAG)

C. Being able to express yourself to the right people is important to you. (MTGS)

6. A. Are you afraid that after you reveal yourself to me I will also tire of you and withdraw from you? (MTIT)

B. What makes you think that they're really trying to avoid you? (MAW)

C. You sound surprised that your friends are growing tired of your helplessness. (MAG)

7. A. How frustrating when all your hard work to please your friends only serves to drive them away from you. (MTGS)

Appendix E--continued

B. People who try so hard are usually trying to hide something. (MAG)

C. Do you ever do things to antagonize your friends? (MAW)

8. A. Tell me more about the depressions, how bad are they? (MAW)

B. It's almost like you feel you have to justify your anger to me. You must be concerned about how I'd react. (MTIT)

C. I don't think that pretending you're not mad at them will help you regain your friends! (MAG)

9. A. What ever made you think that working so hard was an appropriate strategy to get people to like you? (MAG)

B. Are there times when you are relaxed and not working so hard? (MAW)

C. It's almost like you're not worth being around unless you're working hard to engage others. (MTGS)

10. A. It sounds as though conflict is somehow threatening for you. I hope we'll be able to explore our differences when we don't get along in here. (MTIT)

Appendix E--continued

B. Did you ever fight with your brothers and sisters? (MAW)

C. No major disagreements ever! I guess time sure has a way of camouflaging feelings and events. (MAG)

Subject No. _____

Hostile Female--Kim

Response 1. A. So you want me to look into my crystal ball and tell you the real truth about your boyfriend. (MAG)

B. Maybe you could start by telling me a little about your boyfriend. (MAW)

C. You're feeling somewhat uncertain about your boyfriend and you're looking to me to quell your suspicions. (MTIT)

2. A. What do you usually do when you get angry like that? (MAW)

B. You're really angry about his immaturity, and you really want him to know it. (MTGS)

C. So if you don't care why are you wanting me to confirm your feelings? (MAG)

3. A. Have you found this pattern occurring in any of your other relationships? (MAW)

B. His lack of attention seems to have hurt you. (MTGS)

Appendix E--continued

C. I guess there's no way you could assume any responsibility for this. (MAG)

4. A. It seems like it's very hard for you to make yourself vulnerable to him. (MTGS)

B. If you're not affected by what he does why are you wasting therapy time talking about his behavior? (MAG)

C. Would he agree to coming in for therapy with you? (MAW)

5. A. For such a self-assured person you seem pretty confused! (MAG)

B. You seem to be receiving a lot of support from your friends. (MAW)

C. Trying to gain control over this relationship seems really exhausting for you. (MTGS)

6. A. You sound angry now, and you're wanting me to confirm that you're worth better treatment than you're getting. (MTIT)

B. Have you been treated better by others you've been involved with? (MAW)

C. I'm beginning to think that you're going to argue with me just for the sake of arguing. (MAG)

7. A. What changes do you think he needs to make? (MAW)

Appendix E--continued

B. It seems like both of you have some things to face up to! (MAG)

C. You're pissed at me because I'm not paying enough attention to how he treats you. (MTIT)

8. A. It's the people who always have plans that are usually running away from something. (MAG)

B. Do you ever stand him up? (MAW)

C. He doesn't stand you up, but it must be disappointing when he doesn't get there. (MTGS)

9. A. Of course you don't like these questions, I'm making you think about things you would rather not consider! (MAG)

B. It seems like it's hard for you to expose yourself in here. (MTIT)

C. What do you want to talk about? (MAW)

10. A. But in a way that leaves very little room for others to take care of you, and I wonder if you're going to let me be warm to you. (MTIT)

B. Maybe that's the problem, you've got too caught up in taking care of yourself. (MAG)

C. Are you considering giving up this relationship and finding another boyfriend? (MAW)

Appendix E--continued

Subject No. _____

Dependent Male--Steve

Response 1. A. I guess you better keep being so nice or else she might discover how uninteresting you can be. (MAG)

B. It sounds like in trying so hard you've somehow lost contact with yourself. (MTGS)

C. Has this relationship changed over time? (MAW)

2. A. How does she view this relationship? (MAW)

B. You're really scared that you're losing her. (MTGS)

C. So you smother her, and quite naturally she needs to flee. (MAG)

3. A. Tell me a little bit about her, what's she like? (MAW)

B. Do you act as helpless with her as you do with me? (MAG)

C. She's slipping away and you don't know what to do to keep her and you hope I have the answers. (MTIT)

4. A. Even in here it's hard for you to clearly pinpoint and express what you want from her. (MTIT)

Appendix E--continued

B. That's a change of pace, you almost managed to disagree with me, what happened? (MAG)

C. What do you get out of this relationship? (MAW)

5. A. Do you think you're going to get me to like you by praising me? (MAG)

B. I'm a little confused, can you tell me what your rules for relationships are? (MAW)

C. It sounds like it's important for us to get along. (MTIT)

6. A. You're really frightened by that other side that you keep hidden. (MTGS)

B. What other ways do you have of dealing with your anger? (MAW)

C. Unfortunately, what you keep hidden is certainly more engaging than what you show! (MAG)

7. A. Maybe we should talk about how you came to believe that you need to go along with the wishes of others. (MAW)

B. While you're frustrated with the situation I sense a hesitancy in you about venturing out and changing the basic pattern without my direction. (MTIT)

Appendix E--continued

C. Why do you choose to retreat into confusion rather than argue with me? (MAG)

8. A. Losing her is somehow more painful to you than losing yourself. (MTGS)

B. Why are you so eager to compromise yourself for her? Is you self-respect that low? (MAG)

C. Tell me a little more about what needs she fulfills for you. (MAW)

9. A. I just can't believe that she's always right and you're always wrong! Tell me, what do you get out of playing this martyr role? (MAG)

B. Do you tend to try to make other friends happy too? (MAW)

C. You're hoping that I can show you how to be more pleasing to her and relieve your worries about losing her. (MTIT)

10. A. Tell me a little bit about the quality of your time together. (MAW)

B. It's almost like you feel so connected to her that your own happiness depends on her being content. (MTGS)

C. It sounds like you manipulate her rather well. (MAG)

Appendix E--continued

Subject No. _____

Hostile Male--Manny

Response 1. A. Do all your relationships seem to follow the same pattern? (MAW)

B. It must be rather difficult not to be able to share yourself with others. (MTGS)

C. Your arrogance may intimidate others, but trying to maneuver yourself into a one-up position in here will only waste valuable time in therapy. (MAG)

2. A. Being superior really seems to cost you a lot. (MTGS)

B. Did your family place a lot of importance on intelligence? (MAW)

C. It seems like you're pretty blatant about your superiority. (MAG)

3. A. Were you competitive with your siblings or neighborhood friends as well? (MAW)

B. If you're as pleased with yourself as you say, why did you even come for therapy? (MAG)

C. You seem somewhat frustrated by the outcome of your competing needs, it's almost as if your desire for intimacy gets overshadowed by your need to win. (MTGS)

Appendix E--continued

4. A. Do you have any idea where this idea comes from? (MAW)
   B. It might be devastating to lose. (MTGS)
   C. That's not hard to understand, it's easy to win when you don't let yourself be challenged. (MAG)
5. A. You really speak strongly about this, who are you trying to convince? (MAG)
   B. How do you go about lowering your standards? (MAW)
   C. These special qualities and talents really keep you apart from others in some way. (MTGS)
6. A. If I am, why would that bother someone of your stature? (MAG)
   B. It's hard for you to trust that I'm on your side. (MTIT)
   C. Could explain that more? (MAW)
7. A. It almost sounds as if you've given up hope of finding others who will meet your demands. I'm wondering if you're expecting me to disappoint you to? (MTIT)
   B. Your condescending attitude communicates more than you're aware of. You put high demands

Appendix E--continued

on others, but have low expectations that others will measure up. (MAG)

C. Do people expect a lot from you? (MAW)

8. A. Do you find it difficult to maintain friendships in general? (MAW)

B. Talking about weak points with me is rather difficult for you. (MTIT)

C. Do you typically attack when you feel threatened? (MAG)

9. A. I think that you're more comfortable keeping your distance from me, and I can sense how hard it would be for you to become involved in here. (MTIT)

B. Do you feel the same loss of control in other areas of your life? (MAW)

C. I'm not easily intimidated! You'd have to be far more imposing than you are to shake me up. (MAG)

10. A. You're rather harsh in your judgment of other people's feelings. (MAG)

B. What kinds of things interest you? (MAW)

C. It must feel awkward to you to expose your emotions in here since you feel that way about emotions. (MTIT)

APPENDIX F
PERSONAL DATA SHEET

Subject Number: _____

1. Sex _____

2. Age _____

3. Highest degree received to date: _____

   Year received: _____

4. Currently a student in: Clinical Psychology _____

   Counseling Psychology _____

   Counselor Education _____

5. Currently on internship: Yes _____ No _____

   If yes, indicate type of site: _____

6. Number of practicums taken to date: _____

7. Approximate number of patients/clients you have worked with who could be described as overtly hostile. Overtly hostile clients are critical of others, express feelings of superiority and entitlement, have little respect for the rights of others, find it difficult to admit any weakness, and tend to respond to criticism by attacking or devaluing the source. These clients present themselves as invulnerable and invite others to admire them. _____

Appendix F--<u>continued</u>

8. Approximate number of clients/patients you have worked with who could be described as overtly dependent. The dependent clients readily express feelings of inadequacy, strive for acceptance from others, respond to criticism and rejection with further attempts to gain the source's approval, and readily acknowledge being hurt while adamantly denying feelings of hostility. The dependent clients seek nurturance from others and establish a submissive and compliant position with relationships. _____

9. Approximate number of patient/clients you have worked with in individual therapy/counseling: _____

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